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Hypertensive Disease*

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HYPERTENSIVE disease, often called "essential hypertension," must be distinguished from the state of hypertension. Hypertension *per se* is not a disease but a physiologic state which is but an exaggeration or distortion of the normal circulatory mechanism. An adequate intra-arterial pressure is vital to the maintenance of the circulation, just as a warm internal temperature is necessary for life. It is not until the temperature *rises* that it is abnormal and fever is said to exist. Fever results from a disturbance of the thermal equilibratory processes but it is not a new phenomenon. Likewise, the arterial tension is abnormal only when it is unduly raised or lowered. Similarly, these changes do not involve any new or strange mechanisms. Hypertension may exist temporarily without hypertensive disease. The blood pressure rises with anger or fear or effort. Such fluctuations do not constitute disease. The term "hypertensive disease" implies persistence of the disturbed state and definite progression.

Definition.—Hypertensive arterial disease may be defined clinically as a chronic progressive disorder of homeostasis with a consistent pathogenesis in which generalized hypertonicity of the arterioles leads to impairment of tissue nutrition and degenerative changes in the arterioles. The hypertension of the upper extremities observed in instances of coarctation of the aorta is not due to arteriolar constriction, is not progressive and does not lead to degenerative changes in the arterioles. Such hypertensions, therefore, though chronic, are not identical with hypertensive arterial disease. The fundamental factor in hypertensive disease is the persistent arteriolar constriction. The greater the constriction of the myriads of arterioles, the greater the peripheral resistance to the circulation. This thesis must be kept in mind constantly if therapy is to be sound and effective. All the damage done by hypertensive disease is either due to the histanoxia of impaired capillary flow or to the increased cardiac burden in overcoming the augmented peripheral resistance. The arterioles control not only the flow or irrigation to the fertile fields below the arteriolar dam, but the pressure back of the dam.

The Pendulum Swings

Perhaps the most significant advance in medical thought since the introduction of bacteriology has been the change in appreciation of many of the phenomena of disease. Formerly all symptoms or signs were changes to be energetically combatted. It is not so many years since teachers of therapeutics devoted most of their precious lecture time to antipyretics. Now fever is induced as a therapeutic agent! The recognition that many phenomena of disturbed physiology, such as fever, edema, leukocytosis or hypertension, are compensatory physiologic adjustments and may be valuable defense reactions on the part of the body, has done more to bring sanity and logic into therapeutics than any other concept. The appreciation of this viewpoint is

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still young and there are vast unexplored fields yet to be studied. It might be interesting to speculate upon how much the advent of bacteriology delayed the full appreciation of these truths: Was not pus once called laudable? The ancient phrase "laudable pus" has been the butt of abuse and derision for it was forgotten that it was not the pus that was damnable, but the infection! In the presence of pyogenic infection the formation of pus and the development of a leukocytosis may be as desirable as fever in pneumonia.

We must be cautious in not letting the pendulum of thought swing too far. To insist that the phenomena of disease are not necessarily wholly undesirable does not imply that they are without potential detriment. Each problem must be appraised individually, both quantitatively and qualitatively. Pyrexia may be a defense mechanism in generalized infections but hyperpyrexia may well be fatal. It is characteristic of biologic reactions that response to stimulation is frequently in excess of requirements. Overcompensation is the rule rather than the exception. This is illustrated by scar formation; until the connective tissue contracts there is more new tissue than there was originally. Hypertension arises as a result of constrictor stimulation of the arterioles: the reaction of spasticity is one of overcompensation. Cognizance of this should explain why it may be more desirable to reduce the arterial tension only slightly rather than to theoretically normal levels.

Theory of Treatment

Thus, if hypertension is a physiologic phenomenon which may be desirable to the body economy, or even necessary thereto, why should we be concerned with therapeutic measures designed to reduce the arterial tension? There are several reasons. Overcompensation of physiologic reactions usually cease with the termination of stimulation. This is not characteristic of arteriolar hypertonicity. Arteriolar spasticity reveals a strong tendency toward self-perpetuation. It appears to lower the threshold of stimulation and make the musculature of the arteriolar media more sensitive to normal vasomotor stimuli than it was before. Furthermore, the hypertonicity is progressive. This progressiveness is usually slow, but extremely persistent. **There is no inclination toward spontaneous remission or cure. With moderate or mild hypertension the patient is not particularly jeopardized and active therapy would be largely unnecessary were it not for the fact that persistence of the hypertonia slowly leads to progression of the disorder, degenerative changes in the vessels and inevitable jeopardy later on.**

Excessive elevation of the arterial tension is precarious. Therefore, arrest of the progression is essential.[10] The management of hypertensive disease must be prophylactic in attitude.

In late hypertensive disease the arteriolarsclerotic changes are fixed and irreparable. Early in the pathogenesis, however, the changes are reversible and amenable to therapeutic control. Prophylaxis involved two objectives: (1) Prevention of the disease and (2) arrest of the progression. The former depends upon the earliest possible discovery of hypertension and the latter upon relatively early institution of therapy. It is important to keep in mind that reduction of the arterial tension should be slow and gradual if we are to avoid difficulties from "relative hypotension"[11] and disturbing symptoms arising from abrupt changes in circulatory equilibrium.

By postponement of arteriosclerosis we reduce the injury to vital structures such as the brain, myocardium or renal parenchyma. The cardiac insult in hypertensive disease is twofold. Not only is the myocardium deprived of its normal quota of oxygen but it is required to carry an ever-increasing burden of work in overcoming the rising peripheral resistance. Reduction of excessive hypertension reduces this element of cardiac overwork.

All therapy is based upon three fundamental principles: (1) Correction of etiology, (2) Reduction of the physiologic burdens of the injured structures, and (3) Aid to tissue nutrition and respiration. The omission of any one of these makes for incomplete, ineffective and unphysiologic therapeutics. The treatment of hypertensive arterial disease will be considered along these lines.

Therapy Directed Against Etiology

Curative therapy must be based upon eradication of the etiologic factors responsible for disease. We cannot expect cure of a sore

heel due to a nail in the shoe unless the nail be removed, no matter how many soothing ointments or hot dressings are applied to the heel! Obviously the first and most important problem is accurate etiologic diagnosis.

This is never easy and often most complex because of the multiplicity of superimposed factors. Nothing ever happens from only a single cause. There must be suitable soil and environment as well as seed for development of any action. In many diseases, such as typhoid fever or smallpox, the various factors are almost identical in all instances of the specific disease, and etiologic diagnosis is not very complex. It is not so with hypertensive arterial disease, for every patient presents a new and strictly individual etiologic problem. The etiology of hypertensive disease may be defined as "anything which over a long period of time causes arteriolar irritation in a vulnerable individual." In clinical practice it is the thoroughness with which etiologic studies are made which determine therapeutic effectiveness more than anything else. Because of this obligatory individualization it is impossible to consider here all the details of treatment.

Etiology involves three major groups of factors: (1) Predisposing; (2) Provoking and (3) Perpetuating influences. These may vary in their relative importance but are, nevertheless, invariably involved. For example, in the instance of an acute contagious disease the predisposing factors of low immunity and exposure and the provoking factor of the specific bacteriologic organisms are far more significant than any perpetuating forces. With cancer, on the other hand, the predisposing vulnerability of the individual and the powerful, though unexplained, perpetuating factors are of much greater moment than the provoking or initiating irritants. In hypertensive arterial disease, as in all disorders, full and painstaking search for all the contributory factors is prerequisite to intelligent, logical and physiologic therapy.

There are many who deny that hypertensive disease has any cause. The very term "essential hypertension" implies hopelessness of learning the cause. Such assumptions are absolutely unwarranted and serve only as excuses for those too indolent to search for the causative factors. We will not find truth unless we exert ourselves to search. Although the factors are many they may be classified into an orderly scheme. Complete discussion of all the etiologic factors is impossible here, but a condensed tabulation of the more significant influences may clarify the problem.

Condensed Classification of Etiologic Factors in Hypertensive Disease[11]

I. Predisposing factors (vulnerability or constitutional factors):
   1. Hereditary vulnerability
   2. Emotional instability (worrier personality)
   3. Sthenic physique
   4. Constitutional endocrinopatheis
      a. Thyrotoxic
      b. Diabetic
      c. Virilescence
   5. Anatomic anomalies

II. Provoking factors (initiating or precipitating factors):
   1. Intoxications
      a. Endogenous (metabolic)
         (1) Fatigue
         (2) Endocrine disturbances
         (3) Nephritis
         (4) Pregnancy
         (5) Anemia
      b. Exogenous
         (1) Metals (Pb, Ar, et cetera)
         (2) Drugs
         (3) Tobacco (??)
         (4) Dietary habits
            (a) Alcohol (??)
            (b) Excesses of condiments
            (c) Excesses of salt (?)
            (d) Excesses of protein (?)
            (e) Inadequate water
   2. Infections
      a. Focal infection of long duration
      b. Generalized infection (e.g., Influenza)
      c. Syphilis (?)
   3. Neurologic factors
      a. Increased intracranial pressure
      b. Fatigue from worry, stress, etc.

III. Perpetuating factors
   1. Intrinsic in pathogenesis[10]
   2. Renal histanoxia[5,6,18,10]
   3. Cerebral histanoxia
   4. Habit of arteriolar musculature
   5. Intrinsic vulnerability invites recurrences and exacerbations from any provoking factors

Such a highly condensed outline can do little more than suggest the type of factors involved and where to search for them. The last item mentioned is of particular clinical significance. To illustrate: hypertensive arterial disease arises in a vulnerable woman following her last pregnancy, and is acutely exacerbated at her climac-

teric; with appropriate therapy this is brought under control until an acute influenzal infection gives rise to another severe acceleration of the progressing hypertension. We must constantly keep in mind that the presence of hypertensive disease implies vulnerability to arteriolar excitation and irritation and that, therefore, recurrences and exacerbations may arise from a great many provocative influences, either singly or in combination.

Predisposng Factors.—The predisposing factors are, naturally, the least amenable to therapeutic correction. We can accomplish little or nothing with constitutional vulnerability determined by heredity years before the onset of the illness. Nevertheless, an evaluation of these factors is essential, particularly in the early detection of the disorder when prophylactic measures are most effective. By means of the *Cold-Pressor Test,* devised by Hines and Brown,[8] it is possible to determine abnormal vasolability even before the appearance of hypertensive disease. Discovery of such potential hypertension[12] is of great importance in prophylaxis.

Application of this test to children[2] has revealed that such vulnerability is distinctly an inherited characteristic and thus by forewarning of the potential menace permits advising preventative avoidance of unnecessary insults to the circulatory apparatus at an age where dietary, emotional and other habits are being formed.

Provoking Factors.—Etiologic treatment directed against provoking factors can be more specific. It is here especially that therapy must be highly individualized, for each patient presents new and different problems. A few illustrative examples must suffice. Removal of foci of infection, endocrine medication, measures to combat chronic plumbism, attention to chronic renal disease and correction of unwise habits are a few of the modes of attack which may be indicated by the specific provoking factors elicited. Infections or intoxications which may have initiated the progression of hypertensive disease years previously are, of course, but little open to therapeutic attack.

Diet

Just what constitutes the proper dietary for the hypertensive patient has been the subject of much controversy. Theories and fads have come and gone as additional knowledge dispelled the obscuring mists. At the present the prevailing attitude is one of surprisingly good sense: *moderation in all things.* Protein, which was formerly radically restricted, is now permitted in at least normal amounts and when anemia coexists with the hypertension may be wisely increased above the usual intake. It is immaterial whether meat be "white" or "dark"—experimental studies have exposed the fallacy of the older apprehension concerning "red" meat. That the abuse of spices and condiments is unwise is now generally accepted. The sharp condiments are potential vascular and/or renal irritants and add nothing of value to the rations. Salt is required—in moderation. The régimes of horror on "salt free" diets are happily affairs of the past. Reduction of weight in the obese hypertensives is important because of the additional cardiac burden imposed by the obesity. Neither coffee nor alcohol need be forbidden, but they should be taken with temperance and used rather than abused. There is great variation to the tolerance to tobacco. For some any indulgence is unwise, but others apparently are unaffected by years of smoking.

It is of the greatest importance to remember that the deeply ingrained habits of elderly people are best but gradually modified and that abrupt interdiction of coffee, alcohol or tobacco may do more harm than good. Emphasis on moderation is all important. This moderation applies not only to food and drink but to work and play as well.

Careful inquiry will reveal that a great many hypertensive patients habitually consume too little water. A liberal fluid intake is often of considerable therapeutic assistance. Water is an effective diuretic and it is certainly the safest. Wherever renal functional impairment complicates the picture, a minimum fluid intake of from two to three liters per day is imperatively necessary. The habitual fluid consumption is an aspect of individual dietary routines which is all too frequently forgotten or ignored.

Therapy to Reduce the Physiologic Burdens

Rest.—Rest is the oldest of therapeutic measures. To rest when sick or injured is instinctive with all animals. Rest has both qualitative and quantitative attributes. Rest may be localized, as in immobilization of a broken finger, or generalized, as in sleep. Psychic rest is sometimes best obtained through vigorous physical activity. Sometimes rest may be relatively complete but more frequently rest implies merely reduction of the physiologic burdens to levels slightly below the habitual. The effectiveness of rest depends not only upon its intensity but also upon its *duration.* To accomplish the objective of giving the tissues an opportunity to do their own repairing by relieving them of the necessity of forced continuous activity usually requires more time than the patient willingly relinquishes.

The injured structures are the ones which urgently require prolonged rest. Where rest is required and how it may be acquired will depend upon what structures are injured. Rest for the injured or fatigued structures does not necessarily involve invalidism or confinement.

This second principle of therapeutics is particularly important in the management of hypertensive disease because many of the vascular and cardiac changes are attributable to fatigue.[10] And, rest is the only answer to fatigue.

Arteriolar changes and degenerations in hypertensive disease are due chiefly to exhaustion from the continuous spasticity of the smooth muscle cells of the media.[4,10] The pathologic changes are consequent rather than causative of the arteriolar constriction, responsible for the hypertension. This very spasticity is the essential starting point in the progressive pathogenesis of the disease.[11] A major factor in the premature cardiac exhaustion and defeat in hypertensive disease is the accumulative fatigue engendered by overcoming the constantly increasing peripheral resistance. The objective is thus providing prolonged vascular (arteriolar) relaxation and the reduction of the arterial hypertension is our guide and measure of this vascular rest. The primary concern should be with the arteriolar tonus rather than with transient variations in the arterial tension. It is the patient and not the symptoms of hypertension which should be under treatment.

Vascular Relaxation.—Vascular relaxation may be sought for by several different therapeutic approaches. Psychiatric, medicinal, surgical and physical measures are all applicable. No single "remedy" exists or will be found. Wise management does not rely upon drugs alone but utilized them as adjuncts to a sane régime and simple psychiatry. Less obsession with "treatments" and more concern with treatment will improve results.

The best advice is relatively useless unless it is followed. It does not suffice, therefore, to merely ennumerate to the patient what he should and should not do. In chronic disorders it is particularly important that an intimate and whole-hearted coöperation between the patient and physician be maintained.

Hypertensive arterial disease is not "curable" in the generally accepted usage of the term. It is, however, controllable. This distinction is consequent to the intrinsic or constitutional vulnerability of the patient. Vulnerability is irrevocable and not amenable to therapeutic correction. Thus the potentiality of exacerbations or accelerations of the degenerative changes is always present: hypertensive disease provoked by an intoxication of pregnancy may be acutely and severely exacerbated by a sore throat. For these people especially, safety depends upon constant vigilance. It is wise to make this clear from the first, emphasizing the necessity of prophylaxis. To gain and hold the confidence and coöperation of the hypertensive patient is half the battle won.

Sometimes this is very difficult. The majority of patients with hypertensive disease feel vigorous and well, particularly in the early stages of the disease. The typical hypertensive has a distinct personality[11] which resents restraint, is forceful, ambitious and restless. Habitual worrying is characteristic. They are not truly pessimistic or fatalistic, but are almost constantly concerned with their responsibilities. Hard drivers of themselves, these patients are frequently eminently successful in their chosen careers. But their success is hard won; the price is premature physical depreciation and depletion. Much can be accomplished by sane counsel if

instituted early in the course of the disease before the degenerative changes are irrevocably permanent. Encourage the acquisition of creative hobbies. The therapeutic and prophylactic effectiveness of creative hobbies, the wise investment of leisure[21] and the values of mental relaxation are fascinating subjects which must be passed by regretfully here.

Medicinal Measures

Almost innumerable are the medicinal measures that have been suggested, tried, ardently advocated, found wanting and later discarded. No fully adequate drug is as yet available. Nor is it likely that any single panacea for hypertensive disease will ever be found. Drugs can be but auxiliaries in the management of this disorder, to be applied individually and with critical judgment of their values and limitations. Lack of space prohibits all but mention of a few of the less unsatisfactory medicaments.

Sedatives may prove of considerable value if wisely employed. Because of the prolonged, chronic course of hypertensive disease and the necessity for continuing management for months or years, it is imperative that the risks of drug habituation be kept in mind. The desideratum of mild continuous sedation limits the appropriate drugs to a relatively small number. Sedation aids in arteriolar relaxation, both directly and through diminution of the psychic turmoil. Small doses of the bromides are frequently valuable and may be safely continued for months if the physician is aware of the possibility of bromism. In a large series of patients so treated bromide intoxication required the discontinuance of such medication in approximately three per cent of the patients.[9]

Tissue Extracts.—Tissue extracts of various sorts induce diffuse vascular dilation and reduction of the blood pressure. Extracts of liver, brain, kidney, heart muscle and pancreas have been tried. The effects of all these extracts are transient. They must be administered by injection at fairly frequent intervals. These requirements automatically make such therapy generally ineffective in practice, for the patients decline to continue such "treatments" regularly. The hypertensive feels too well and is far too busy with his many responsibilities to be conscientious with such bothersome therapy. To do the greatest good to the greatest number, medication in chronic illness must not only be safe but also its administration must not be irksome.

Xanthin Derivatives.—The xanthin derivatives effect principally the coronary and renal vessels and have little action upon the arterial tension as a whole. Aminophyllin, theobromine, caffein and many other related compounds are useful chiefly as supportive auxiliaries where the cardiac nutrition is impaired. This occurs late in the course of the disease. Early, when one may hope to accomplish prophylactic arrest of progression, these compounds have been disappointingly ineffective.

Thiocyanates.—Sodium or potassium thiocyanate, induces prolonged vascular relaxation. The pharmacologic action approaches that most desired. But therapeutically effective doses are precariously toxic. Thiocyanate therapy is not safe unless the patient be under close and watchful observation. By frequent determinations of the concentration of thiocyanate in the blood, as suggested by Barker,[3] much of the risk is removed but all the desirable simplicity of oral administration is lost. Furthermore, despite improvement of the analytic methods in the last year or two, the methods are far from satisfactory.

Nitrites.—Nitrites are active vasodilators. The soluble nitrites, such as sodium and amyl nitrite, and the alkyl nitrates may be of inestimable value in acute vasospastic emergencies but the pharmacologic response of arteriolar relaxation is far too fleeting to be of appreciable service in inducing arteriolar *rest.* Prolonged arteriolar sedation is hardly obtainable from drugs whose effects terminate in a matter of minutes. Because a poorly soluble compound which permitted only slow but continuous absorption appeared to be more appropriate, extensive studies on the effectiveness of bismuth subnitrate were made.[10,13] Bismuth subnitrate has a mild and continuous nitrite effect.[10] The nitrate is reduced to nitrite by B. coli. Oral administration of bismuth subnitrate in moderate doses increases the concentration of nitrite in the blood to about three times the normal content, as does sodium nitrite.[15] Clinical experience has demonstrated that bismuth subnitrate in doses of ten grains thrice daily

is an effective and valuable adjunct in the treatment of early (spastic) hypertensive disease. The vaso-sedation, however, is very mild; too mild to accomplish much in instances where there are active provoking factors driving up the arterial tension. The same limitation applies to the similarly inorganic sodium nitrite.

So many other drugs have been tried in hypertensive disease that it is impossible to even enumerate them all. One by one they have been tried and discarded. Many are still on the market, heralded by their manufacturers with more enthusiasm than scientific accuracy: amorous mistletoe and repellent garlic, bitter iodides and sweet watermelon seeds are all available! Their very multiplicity betrays their ineffectiveness. A safe, effective vasodilator drug of prolonged action has not yet been found. But we may be sure that synthetic chemistry will ultimately produce such a compound.

Surgical Measures

Surgical measures for the control of hypertensive arterial disease can be considered only briefly here. The chief services which surgery can render the hypertensive patient are the removal of foci of infection, blood transfusions for the nephritic and rarely phlebotomy in acute conjestive cardiac failure. The recent wave of enthusiasm for neurosurgical intervention is already on the wane. The attempts to deprive large vascular areas of their vasomotor innervation and thus reduce the hypertension have been woefully disappointing if viewed after intervals long enough to be significant. That a temporary reduction of the blood pressure follows is undisputed. But the effects are transient.[19] Clinical results enthusiastically reported are actually negligible: reduction of the mean diastolic pressures by 5 to 10 mm. Hg. following extensive sympathectomy. Evaluation of therapeutic effectiveness should be based upon the percentage approach toward normal of the diastolic tension.[16]

The reported improvements imply a correction of approximately 15 per cent of the hypertonia. Such "accomplishments" certainly do not justify the considerable surgical risks involved. When the fundamental pathogenesis of hypertensive disease[17] is given the appreciation it deserves and the complex, multiple etiology is considered, it is quickly apparent that such approaches lack physiologic logic. These surgeons may perhaps be admired for their courage, but not for sound therapeutic sense.

Similarly disappointing and even more radical have been the suggestions anent subtotal adrenalectomy and de-innervation of the adrenal glands. That the therapeutic results are utterly insignificant does not surprise one. Despite oft repeated attempts to show that there is more than a normal amount of epinephrin in the blood of patients with hypertension, this has never been convincingly demonstrated. There are extremely rare instances of severe and violent hypertension due to adrenal tumors. For these cases surgical intervention is logical and the results are dramatic. But such neoplastic or hyperplastic endocrine disturbances account for perhaps one case of hypertension in one hundred thousand!

Physical Measures

Physical measures are frequently beneficial auxiliaries in obtaining the desirable rest and relaxation. Warm baths, massage, sunshine and congenial non-competitive sports all have their place as useful adjuncts in selected cases. The benefits to be derived from sojourns at spas and watering places depend largely upon the economic status of the patient and whether such an environment will be congenial. To urge a man to spend several weeks at an expensive spa, when he can ill afford it, merely increases his worry: the net consequence is harm. We must not forget also that one of the greatest sources of benefit in these places is the increased fluid intake which is usually ritualized; this may be accomplished much more economically at home. Diathermy, appropriately applied, reduces the arterial tonus, but the induced relaxation is but temporary and of little lasting benefit.

Aid in reducing the physiologic burdens of the injured structures in hypertensive disease may be rendered by many different therapeutic measures. The choice and application of these must be individualized, for each patient presents a different psychic as well as physical problem. Wisdom and judgment in the choice of measures distinguish the wiser physician from those chiefly concerned with symptomatic

treatments. Let us learn from Gilbert and Sullivan's Mikado: "our object all sublime" should be to let the therapy fit the patient.

Therapy to Aid Nutrition and Tissue Respiration

This third therapeutic principle is all too frequently neglected. To fail to give it full consideration is to advise treatment which is incomplete and frequently inadequate. In hypertensive arterial disease the measures which are included under this heading are of particular importance. It must never be forgotten that all the damage which is done by hypertensive disease results from interference with the nutrition and respiration of the body tissues because of the consequent impairment of the circulation.

The greater the arteriolar constriction the higher the diastolic tension and the poorer the circulation peripheral to the arterioles.

The clinical and pathologic consequences of hypertensive disease are almost all directly attributable to histanoxia of important tissues. It is hardly just or logical to expect normal and effective physiologic functioning of tissues whose supply of oxygen is inadequate. There has been an unfortunate tendency to confuse histanoxia (inadequate supply of oxygen to the *tissues*) with anoxemia (lowered content of oxygen in the *blood*). In hypertonia of the arterioles histanoxia exists although there may be no anoxemia. If the two are superimposed, the detriment to the tissues is tremendously enhanced.

Anemia.—This is just what occurs when anemia co-exists with arterial hypertension. As mentioned previously, the two do often occur in the same patient. The coincident or related anemia invariably aggravates the insult to the tissues. Therefore correction of anemia is frequently the most important therapeutic aid which we can give the hypertensive patient. It has been observed repeatedly[20] that correction of anemia alone causes considerable and lasting reduction of the arterial tension. The anemia probably has some as yet poorly understood etiologic relation to arteriolar spasticity. It is not difficult to visualize the benefits of such correction to partially asphyxiated renal parenchyma, to the brain or to the struggling myocardium.

Relaxation of unduly constricted arterioles will in itself improve the tissue circulation. Thus reduction of the arterial tension through arteriolar dilation is indicated on the score of improving tissue nutrition as well as reducing the physiologic burden of the spastic arteriolar musculature. Specifically limited impairment of the renal function is the rule in hypertension. These changes, however, are usually so inconspicuous that renal function studies are necessary to detect them.[18,19] If in lowering the arterial tension the renal arterioles are *less constricted* improvement in the renal functional activity may be expected.[10,20] If the arterial tension falls through loss of cardiac force (systolic rather than diastolic reduction[11]) and the renal vessels *remain constricted*, renal decompensation may impend.

Food Restriction.—Nutrition, however, involves more than the tissue supply of oxygen. A well balanced ration is necessary: prolonged application of severe dietary restrictions frequently do more harm than good. It is especially important that the supply of protein be not excessively curtailed, for a diet deficient in protein handicaps hematosis and the normal nutrition of vitally important parenchymatous tissues. This is particularly true when renal disease complicates hypertension: albuminuria is not an indication for restriction of protein in the diet but rather a reason for increasing the protein intake to replace that which is being lost through the urine. The recent and significantly suggestive researches of Goldblatt[5,6] and others have re-emphasized the rôle of the kidneys in the etiology of hypertensive disease. Anything which the physician can do to improve the renal circulation and thus the renal respiration and nutrition, will be of great and lasting benefit to the physiologic balance of the hypertensive patient.

Conclusions

It has been the intent to point out that a thorough understanding of the etiology, the pathogenesis and the mechanisms of hypertensive arterial disease are essential prerequisites to intelligent therapy. The management of the patient includes many factors, among which drugs play but a minor rôle. It cannot be reiterated too often that each instance of hypertensive disease presents individual problems in etiology,

prognosis, and treatment. The institution of routine methods of treatment is never justified.

Hypertensive disease, if detected early and properly taken care of, is a controllable disorder, although it cannot be considered as curable. Until extensive and irreparable damage has been done late in the disease the therapeutic attitude must be one of prophylaxis. The great majority of hypertensive patients are in no immediate jeopardy and the problems resolve themselves into attempts to halt the progression of the disease and postpone as long as possible the ultimate termination. Of great importance is the constant recognition of the significance of the intrinsic vulnerability of the arteriolar mechanism to irritation and stimulation. This constitutional vulnerability, or instability, is not amenable to correction.

Therefore, exacerbations and recurrences of hypertension are to be expected from any of the innumerable sources of arteriolar irritation to which such patients are exposed. Constant observation and control are necessary if such exacerbations are not to undo all that which had been previously accomplished.

Hypertension arises fundamentally through biologic overcompensation of the arterioles to constrictor stimuli, irrespective of the origin of such stimuli. It must not be forgotten that the phenomena of increased arterial tone are basically compensatory, and are, therefore, not necessarily wholly undesirable. A gradual moderate but prolonged diminution of arterial tension is far more beneficial, though less dramatic, than rapid, but transient reduction.

All curative therapy falls into three fundamental categories: (1) Therapy directed against etiology; (2) Therapy intended to reduce the physiologic burden of injured structures: rest; and (3) Therapy directed toward improvement of tissue respiration and nutrition. To neglect the institution of any one of these principles is to advise incomplete and inadequate treatment.

Effective application of the first principle is wholly dependent upon the discovery and recognition of the etiologic factors: these will vary with each individual case. In hypertensive disease relaxation or sedation of the hypertonic arterioles constitutes the major approach to the second principle of therapy. The effectiveness of such measures is revealed by reduction of the diastolic tension. Evaluation of therapeutic results should be based upon observations of at least a year and the percentage approach toward normal rather than upon the mere millimeter fall of the tension over a few weeks or months.[16] The most significant application of the third principle of therapeutics in the management of hypertensive patients consists in correction of any anemia. Even minor depressions of the hemoglobin content of the blood may prove physiologically important.

We can accomplish most by attacking the problem as a whole and including all the many different factors in our considerations. The psychic aspects of the characteristic hypertensive personality and the economic problems of the patients warrant attention as well as the more purely physical factors. It is the patient, not the disease alone, that we must be concerned with. Before dispensing any advice, no matter how trivial or how serious, weigh the probable benefits against the probable detriments. If they are about equal—don't do it.

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Indirect Blood Transfusion

Vacuum and Pressure Method

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■ The indirect method of blood transfusion by vacuum and pressure was first used at Providence Hospital, Detroit, Michigan, in 1934, and has now been in use almost exclusively for two years, with very gratifying results.

We have all, no doubt, at one time or another, officiated at an indirect blood transfusion, and have cut down on the vein, inserted the canula, or needle, and have waited, holding the receptacle containing the sodium citrate, or sodium oxalate, fifteen, thirty or forty-five minutes for a sufficient quantity of blood. Having done so myself I concluded there must be some more rapid method and so devised one in which negative pressure could be created that would permit the blood to be drawn from the vein, as with a syringe and needle.

Equipment

A standard Cutter flask, made by the Cutter Laboratories, Berkeley, California, was used. This flask is graduated to 1,000 c.c. A rubber stopper with two openings is inserted. Through each opening I introduced two glass tubes. One is placed flush with the inner surface of the cork, and the other so that it comes about one inch from the bottom of the flask. To each a moderately flexible rubber tube, about one foot in length, is connected. Attached to the end of the long tube is an adapter, to which a large transfusion needle could be connected, and in the short tube is a two-way cork adapter, to which a 50 c.c. syringe was attached (Fig. 1).

Thus far a set-up for the removal of blood from the donor is complete except for the sterilization of the apparatus, preparation of the recipient and donor by laboratory methods, preparation of the donor's arm and tourniquets.

Next, using about 50 c.c. of 3 per cent sodium citrate, which is prepared in ampule form by many of the pharmaceutical companies, the transfusion needle is placed into its container. By withdrawing the plunger in the syringe, after having turned the valve in the two-way stop-cock adapter so that it is in direct communication with the flask, a negative pressure is created in the flask, resulting in the sodium citrate being drawn through the needle and rubber tube into the flask, thereby coating the tube with an anti-coagulant and placing it where it is desired. Rapidity of withdrawal of blood through the tube lined with sodium citrate prevents clot formation.

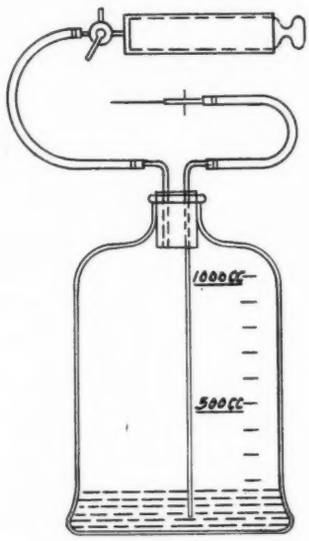

Fig. 1.

Collection of Blood

Next comes the difficult procedure of inserting the needle into the vein. It has been found that a great number of operators will apply the tourniquet too tightly, causing a constriction, not only of the venous circulation, but also of the arterial, thereby inhibiting the flow of blood to the extremities where it must go before it can be used. Therefore, make it a duty to feel that the radial pulse is full and bounding before attempting to insert the needle. Also, do not attempt to go directly down into the vein, but start into the skin about a half- to three-quarters of an inch from the side of the dilated vein. This, also, permits the use of a local anesthetic without obliterating the sight of intended puncture of the vein. This will be found to be very useful in transfusing children.

To enter the vein, slide the point of the needle, bevel away from the vein, and the longitudinal axis of the needle almost parallel with that of the vein, so that it may be drawn into it and not aimed and jabbed at the vein. The larger the needle used the more rapidly is the blood obtained.

After the needle is well inserted, by manipulating the syringe and stop-cock a constant negative pressure can be maintained in the flask. Gently

agitate the flask while drawing the blood and you will find that five hundred c.c. of blood can be obtained in approximately ten minutes, or less.

Transfusion of Blood

After withdrawal the top of the flask is covered with sterile gauze and placed in a pan of warm water at body temperature and brought to the patient's room. Here the tubing is removed from the flask (glass tubes being left in place), a long, sterile, rubber venoclysis tube, washed in sterile saline solution, is connected with the shortest of the two glass tubes, and the position of the two-way stop-cock adapter is reversed to the long glass tube. Another sterile rubber tube is attached to the second valve of the stop-cock and a small glass funnel is attached to this, filled with cotton, and held at the level above the blood container which is now inverted and hung on a hanger above the patient's bed. Filtered air can now be used drawn through the cotton, forced into the bottom of the flask, which is now uppermost, causing a positive pressure and a more rapid evacuation of the blood from the flask into the vein of the recipient, regardless of the size of the needle used.

Certainty can be made that the needle is in the recipient's vein by lowering the flask below the level of the bed with the flask in the upright position. Entrance will result in some blood returning to the bottle.

Make certain that with the positive pressure used the rubber stopper does not come out and spill the contents of the flask over the patient and bed.

Some prefer not to use the positive pressure method of introducing the blood into the recipient's system. The only complaint regarding this method is that one must remain and observe the patient closely so that the needle does not slide out of the vein, causing a hematoma.

Emergency Set-up

Packs should be sterilized in advance for preparedness in emergency use. These consist of:

1. Rubber stopper with the two glass tubes in place.
2. Rubber tubing—one long, leading to recipient, with needle and glass adapter, and three others, about one foot long.
3. A two-way stop-cock adapter.
4. A fifty c.c. syringe.
5. Sodium citrate
6. Novocain, hypodermic syringe and a fine needle.

The flasks need only be sterilized when necessary and before using washed out with sterile saline solution.

One of the greatest advantages realized in this method is the increased sterility and lessened probability of contamination because it is an entirely closed procedure. This method is also conveniently used in the removal of blood from a donor for storage for use at a later date.

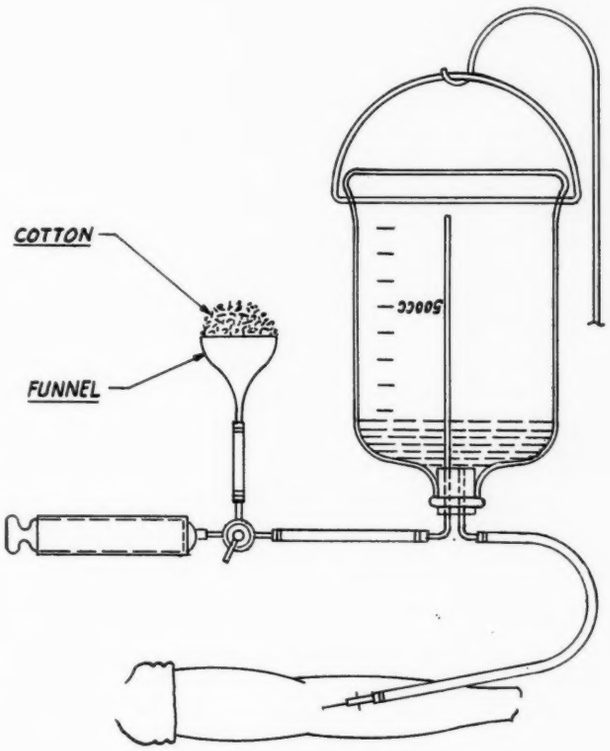

Fig. 2.

Conclusions

1. It is believed that the use of this type of blood transfusion technic will relieve the surgeon of many of the worries of contamination often found in other methods of indirect blood transfusion because of the closed system employed.

2. Much valuable time is saved between the drawing of the blood and the receiving of it by the recipient. This is especially valuable in emergencies when the direct method is for some reason not available or practical.

3. A valuable adjunct to home therapy with but little cost for expensive apparatus.

4. A successful attempt to approach the simple technic of removal of blood and injection of it by the syringe and needle method.

5. An attempt to minutely describe the tech-

nic of inserting the needle into the vein. This, if practiced, will exclude the necessity of having a dissecting set ready for use except in case of collapse.

6. A method of using a local anesthetic in conjunction with blood transfusions without obliterating the sight of expected puncture.

Delivery of the After-Coming Head

A Modification

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■ The use of external abdominal pressure in delivery of the after-coming head has almost become routine, but the procedure used to apply this pressure varies greatly. Since Mariceau first described his method in 1668, for the delivery of the after-coming head, it has been used extensively with minor modifications. Early in the 19th century Wigand and E. Martin described a method for the extraction of the after-coming head which Winckel gives as follows: "The first and second fingers of the hand whose palm corresponds to the face are introduced into the mouth, and the lower jaw is directed to the middle of the pelvis, after which the child's body is placed astride the arm, and then the fetal head is forced down through the small pelvis by pressing upon the occipital region." In reviewing five widely used texts of obstetrics only one made specific mention of a method used in applying pressure externally upon the occiput. The procedure of applying the external pressure is of the greatest importance. As illustrated in the drawing (Fig. 1), the fingers are just above the symphysis pubis when the pressure is applied to the occiput. This is necessary to avoid the placenta, which is usually located on the anterior or posterior walls of the fundus, and rarely between the fingers and the occiput. This allows for better and gentler application of pressure to the occipital region with less effort and greater efficiency. The pressure can be applied with either the right or left hand as the case may be and only the index finger is necessary in the baby's mouth. I find that this procedure may be used to better advantage in the smaller hospitals where there are no interns or assistants, and in home deliveries. If the obstetrician would use this method in all his deliveries of the after-coming head, he would become familiar with it and be able to use it when necessity demands.

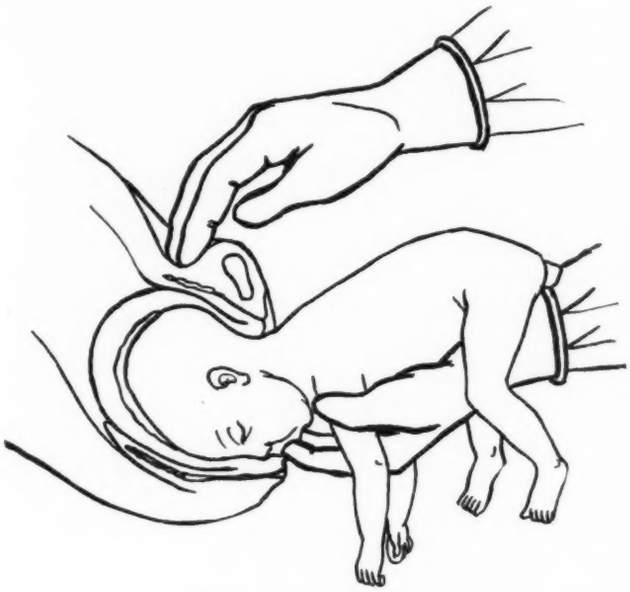

Fig. 1. Procedure of applying external pressure

The advantage of this method is that the operator is able to deliver the after-coming head without the aid of an assistant.

THE SCHOOL PHYSICIAN IN THE PUBLIC HEALTH PROGRAM

Dr. Don W. Gudakunst, New York City—"It is particularly important to emphasize the fact that the school physician is expected to participate in a general public health program. This statement implies that the services rendered by the school physicians and school nurses should be in line with the community health program—particularly should the school physician have an awareness of the part he plays in the health education movement. There is a very healthy trend in many parts of the country toward reduction of the actual amount of service rendered to school children by school physicians and nurses, with a corresponding increase in the educational program—teaching children, families, and the entire community the need for medical service and when and where and how to obtain it."

—From the Discussion of "The School Physician in the Public Health Program" by George M. Wheatley, M.D., *N. Y. State Journal of Medicine,* October 15, 1940.

Early Carcinoma of the Cervix

Diagnosis and Treatment

By Lloyd A. Campbell, M.D.
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■ THE DIAGNOSIS of early carcinoma of the uterine cervix presents one of the more important medical problems which confronts the general practitioner. Too frequently one will observe a patient that gives a history of a long standing, maloderous, bloody vaginal discharge when they first consult their physician. Such a case does not present difficult diagnostic problems, for an advanced carcinoma is generally apparent, even upon a minimal examination, and the blame for delay lies entirely with the patient. It does become the problem and responsibility of the general practitioner to recognize the symptoms and lesions that are suggestive of carcinoma of the cervix in the earliest stages; obviously quite different from the advanced type.

In early clinically recognizable cervical carcinoma an irregular, slightly elevated, and at times an indurated mass or area of various redness is situated near the os, commonly in the posterior portion. Frequently this appears as a small ulcer, the base of which may be a leukoplakic area, a neglected cervical erosion, or lesions embracing inflammatory or chronic irritative conditions. Due to its friable nature the area bleeds readily upon palpation, and because of this, visualization of the cervix should always proceed the digital examination when one wishes an untraumatized field for inspection. Bleeding and friability are the earliest dependable gross signs of carcinoma and a biopsy from such an area affords conclusive histologic evidence for early treatment.

Technic of Examination

Proper visualization of the cervix is the combination of adequate exposure and the correct illumination which will afford the alert examiner every advantage to discover areas which exhibit unusual cell activity.

Every general practitioner has certain speculum, such as the standard bi-valve, which afford adequate exposure and to which he has become accustomed. The addition of a black finish to the speculum, such as that used in photography of the cervix,[3] decreases the reflected light materially annd is a definite help to many, as the cervix is framed in a light-absorbing contrasting color.

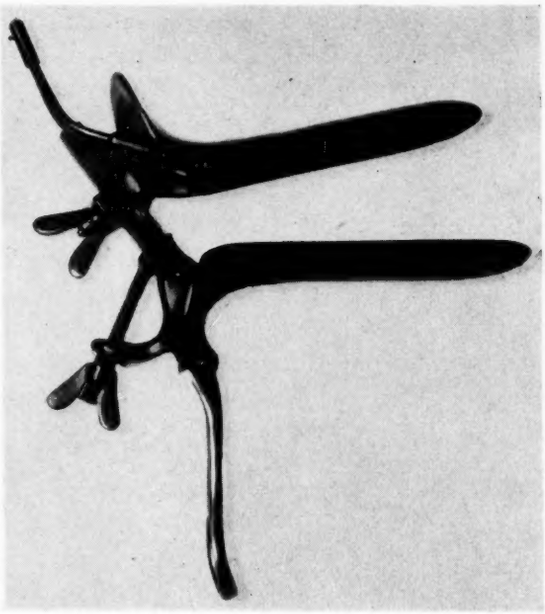

Fig. 1.

In those cases where the vaginal walls tend to collapse to prevent a satisfactory exposure of the cervix, one can use a large size Penrose drain over the blades. This retracts the walls perpendicularly as the blades are separated.

Correct illumination of the cervix is a relative factor, and that which may appear sufficient for one examiner may prove very inadequate for another. As the intensity of light varies inversely as the square of the distance, it is axiomatic that the closer the light is located to the cervix, the better the cervix will be illuminated, considering the focus and spread of the source as sufficient to cover the entire vaginal vault. Thus a light or lights which are located within the speculum and controlled by a rheostat, can be increased in intensity to such a degree that the entire vaginal vault is flooded with a shadowless brilliance without unduly limiting the instrumentation necessary to any cervical examination. This type of unobstructed, intensely-illuminated visualization can be called the camera view and when one observes the cervix under

these conditions more areas will show sufficient deviation from the normal to arouse suspicion and thus guide the operator in his choice of locations for biopsy.

Illustrating the types of everting and inverting carcinoma one commonly encounters are several typical examples in the various stages, from the early bluish-white, smooth, indurated mass to the far advanced cavernous ulceration invading the entire cervix.

Further aids in the early diagnosis of carcinoma are the Schiller test and colposcopy. The technic of the Schiller iodine test is described by many authors[6,8,9] and its value can best be told by Schiller[9] who states, "the reaction is not a specific one, but the use of iodine is a rapid and practical way of finding suspicious alterations that might otherwise escape the examiner. Microscopic examination of the tissue from the white patches is necessary to establish a definite diagnosis." There is no doubt this test would aid the general practitioner in his search for early cervical carcinoma providing he has had the experience necessary for its proper interpretation. Novak[8] states, "the chief value of the Schiller test, even to the expert gynecologist, is to indicate the proper points for biopsy, though in a great majority of these cases the suspicious areas are apparent enough." Of the value of the colposcope he says, "I do not believe that a good gynecologist who examines the cervix very carefully in a very good light will overlook many cancers that the colposcope will reveal." In a similar manner Martzloff[6] says of the colposcope, "in routine use so far we have not discovered areas which could not be detected with the unaided eye on careful methodical examination."

The bimanual examination will often aid in locating indurated masses within the cervix which may show little evidences of their invasive character upon visualization. Palpation will reveal the friable nature of the tumor and guide the examiner in determining the extent and form of the lesion.

According to Healy[5] eighty to eighty-five per cent of all carcinomas of the cervix can be diagnosed by a careful history, a methodical inspection, and an accurate pelvic palpation. However, in early carcinoma, the histologic evidence presented by the biopsy of a suspicious area is absolutely essential.

The dangers of disseminating cancer cells attending the excision of tissue have been overemphasized. With a careful surgical technic sufficient tissue can be obtained with no extra hazard to the patient. The natural sequence to an early diagnosis is the prompt establishment of adequate treatment which offers a better prognosis when the disease is still a local entity.

Treatment

The object of the treatment of cancer of the cervix is the total eradication or destruction of the entire growth by that method which, from clinical investigation and experience, is best suited to the individual case. The object of treatment is not to use surgery because one is a surgeon, nor radiotherapy because one is a radiologist, but to carefully determine that course which offers the patient the best prognosis attended with the least mortality.

Masson[7] says of surgery, "with our present knowledge, the only surgical treatment justifiable, even for lesions of microscopic size, is either the Wertheim abdominal hysterectemy

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LEGEND FOR COLOR PLATE

A. Early proliferating squamous-cell carcinoma of the cervix. Age 23.

B. Case A, five months after radiotherapy.

C. Proliferating squamous-cell carcinoma of the cervix. Age 29.

D. Case C, five months after radiotherapy.

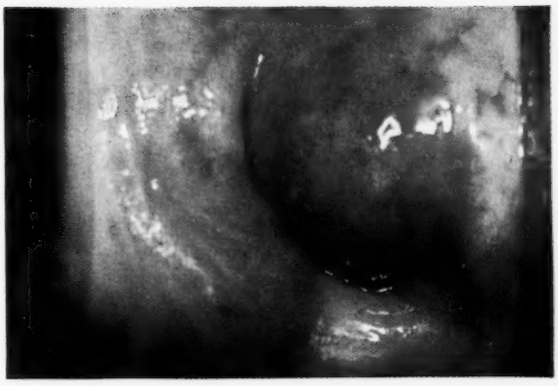
E. Advanced squamous-cell carcinoma of the cervix with ulceration. Age 55.

F. Five years after radiotherapy of early proliferating squamous-cell carcinoma of the cervix. Age 26.

G. Advanced squamous-cell carcinoma of the cervix with ulceration and beginning excavation. Age 41.

H. Advanced squamous-cell carcinoma of the cervix with marked infiltration, ulceration, and cavity formation. Age 50.

A



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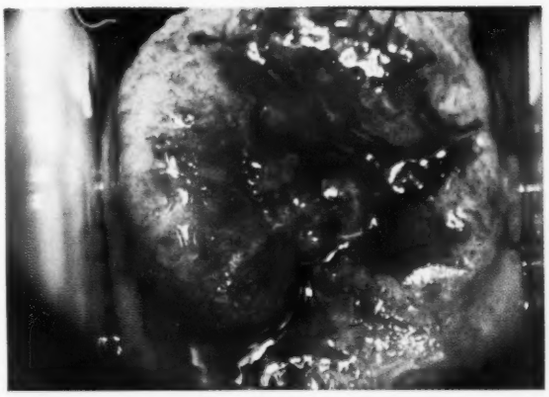

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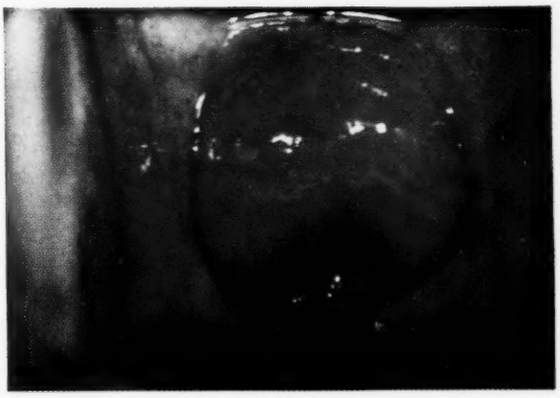

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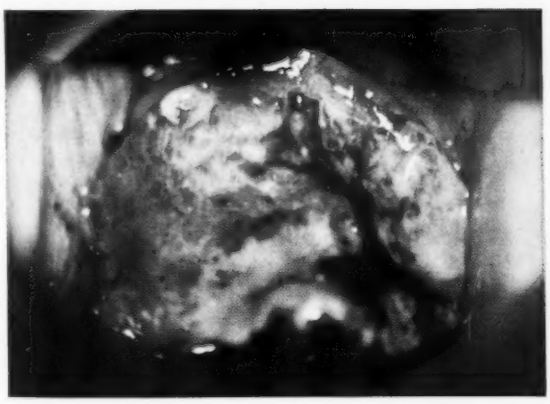

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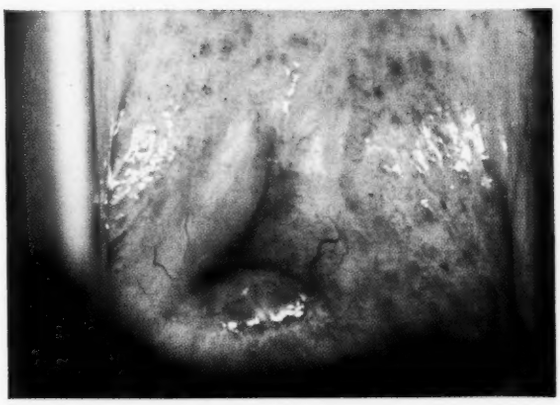

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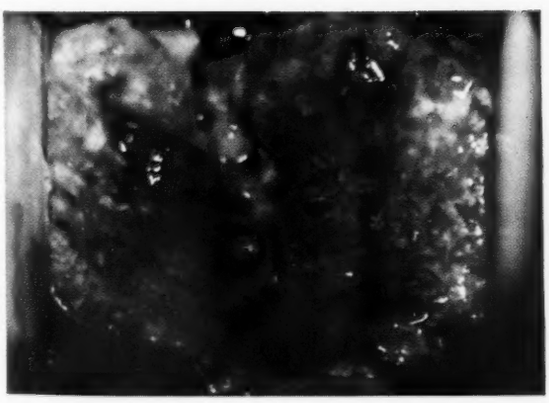

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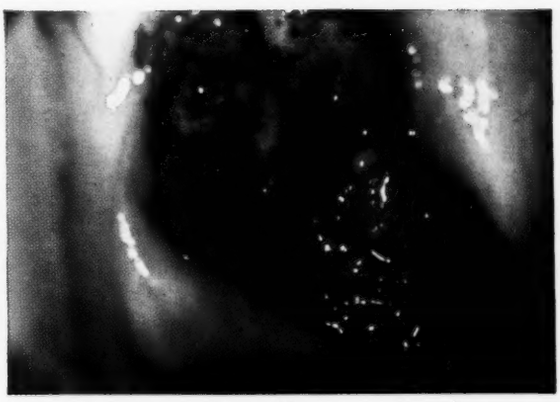

H

or the Schauta vaginal hysterectemy, both preceded by cautery or zinc chloride destruction of the local lesion." Baer[1] states "for the cure of carcinoma of the cervix the old issue of surgical measures versus irradiation scarcely exists any longer. Treatment with radium or roentgen rays or both has almost completely displaced surgical methods in the hands of the most experienced specialists here and abroad."

The therapeutic application of roentgen and radium rays in equal intensities produce the same biological reactions and should be considered as one dose applied by different methods, much as one gives digitalis by hypodermic or by mouth for its action upon the heart. In reality the only difference is that the radium may be applied as a source of radiation within or directly surrounding the tumor, while roentgen rays must be directed from wihout and cover a much larger area. Each has its indications and limitations.

There is general agreement that radium placed within the cervical canal will not control disease located at distances greater than three or four centimeters from the source. Thus, in most patients, radium alone is inadequate to deliver a lethal dose to the entire tumor. In order to increase the radiation to the outlying tumor-bearing areas and lymphatics, high voltage roentgen rays are added in an attempt to extend the zone of lethal action over the entire parametria.

The cervix is located in an area especially favorable for radiation therapy, for the normal tissues surrounding it are able to tolerate far more intensive irradiation than a similar tumor in the mouth or the pharynx, and further, they are capable of being displaced away from the field of greatest intensity.

The susceptibility of the cancer cell to injury or destruction by the action of radium or roentgen rays constitutes what is called radiosensitivity. Bowing and Frick[2] and Healy[4] regard all cervical lesions as radiosensitive, stating they have rarely encountered lesions in which there is a limited response to irradiation.

The trend of radiotherapy is to employ the protracted, fractional dose method, repeating treatments on successive days, not only to irradiate all points sufficiently but to attack the greatest possible number of cells at the time they are dividing; a period in their life cycle in which they are highly radiosensitive.

The improved statistics verify our belief that combined internal and external radiation therapy properly carried out, still offers the best chance of cure to the patient suffering from cancer of the uterine cervix.

Conclusion

The early diagnosis of carcinoma of the cervix together with adequate radiation therapy requires the active coöperation of the general practitioner, the pathologist, and the radiologist. If we are to improve our results, the greatest opportunity is presented by an earlier diagnosis and satisfactory cures should be obtained in 60 per cent of the cases in this early group.

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KIND WORDS FOR THE G. P.

First comes the general practitioner. Nine times out of ten, he is the man you want. We are told that he is losing ground, that he was all right for the horse and buggy days, but that now everybody ought to have a specialist. Now I can speak on this subject with some right to be believed, for I am a specialist myself. But I take off my hat to the good general practitioner. Upon him, I truly believe, depends the health of the race.—Terry M. Townsend, M.D., President New York State Medical Society. Reprinted from the *New York Sun*, April 22, 1940.

Male Hypogenitalism*

By Willard O. Thompson, M.D.
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■ Hypogenitalism in the male may be primary or secondary and may be produced in two ways:

1. Primary disease of the testis.
2. Lack of adequate stimulation of the testis, notably by the anterior lobe of the pituitary.

Primary disease is seen in individuals of the castrate, eunuch and eunuchoid types, those with testicular destruction and atrophy following infection and inflammation of the testes and in some old men with failing testicular function. Lack of adequate stimulation is seen in patients with hypopituitarism including those with the Fröhlich syndrome, and in some patients with undescended testes. In the primary type, substitution therapy with male sex hormone is indicated; and in the secondary type, stimulation therapy, notably with the anterior pituitary-like principle of pregnancy urine.

Physiology

A few simple considerations about the physiology of the testis will help to clarify some of the problems involved. An intimate relationship exists between the anterior lobe of the pituitary and the testis.[5] This is demonstrated by the persistence of infantile genitalia in individuals who develop marked hypopituitarism before puberty, and atrophy of the genitalia in individuals who develop marked hypopituitarism after puberty. The testis consists essentially of two parts: (1) The seminiferous tubules, the most important function of which is to produce spermatozoa; (2) The interstitial cells of Leydig, the most important function of which is to produce male sex hormone. Upon the production of male sex hormone depends the production of the secondary sexual characteristics of the male, which include the development of the external genitalia, the growth of the prostate, development of hair in various parts of the body, change in the pitch of the voice and in the contour of the body. Gonadotropic material is produced in the anterior lobe of the pituitary which influences both functions of the testis. There is some evidence that these two functions of the testis may be influenced by separate gonadotropic principles in the anterior lobe of the pituitary but this is a debatable point. It is thought that one principle influences the function of the seminiferous tubules in the testis and the development of ova in the ovary (so-called follicle stimulating hormone), whereas the other influences the function of the interstitial cells in the testis and causes luteinization of follicles in the ovary (so-called luteinizing hormone). Commercial gonadotropic preparations from the pituitary and from the serum of the pregnant mare contain both factors, whereas those from castrate and menopausal urine contain the follicle stimulating principle, and those from the urine of pregnant women, the luteinizing factor. Selective stimulation of the testis is, therefore, possible although the pituitary and mare's serum preparations are still too weak to produce desired results. The material from castrate and menopausal urine is not available commercially.

The best gonadotropic preparation for the treatment of hypogenitalism in the male is that from the urine of pregnant women. It is available commercially under a variety of trade names. This material acts in hypogenitalism by stimulating the interstitial cells of the testis to produce more male sex hormone, and is indicated whenever the testis is capable of responding to stimulation, whereas treatment with male sex hormone itself represents substitution therapy and is indicated whenever the testis is incapable of responding to stimulation.

The form in which the male sex hormone is secreted and circulates is unknown. The most potent androgenic material which has been iso-

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lated so far from the testis is testosterone. For commercial use this is prepared synthetically. Certain esters of testosterone are more potent than testosterone itself. For clinical work the propionic acid ester (testosterone propionate) is used.

The function of the testis appears to undergo marked alteration at the time of puberty. Studies on the excretion of androgenic material in the urine appear to indicate that very little male sex hormone is produced before puberty. At this time a marked increase in production takes place which accounts for the development of the secondary sexual characteristics.[4] The production is maintained at a high level for about three decades and then appears to decrease to a variable extent, although the data on this point are not extensive enough to warrant conclusions. In some individuals a marked decrease in production of male sex hormone appears to occur in later life, resulting in a condition resembling the menopause in the female. The production of spermatozoa begins at the time of puberty and may show varying degrees of reduction in later life, but commonly persists to old age.[2]

PRIMARY HYPOGONADISM

Eunuchism and Eunuchoidism

Castration early in life produces typical changes in the individual. All of the characteristic secondary sexual changes fail to appear at the age of normal puberty. The genitalia remain infantile. The prostate does not develop. Pubic and axillary hair do not grow. The beard does not develop. The voice remains high-pitched. The shoulders are narrow and the muscles are poorly developed and resemble those of the female. The skeleton shows characteristic changes. The trunk is short in proportion to the extremities, which become abnormally long. The patients are very shy and effeminate, avoid all games in which they must disrobe before other people, shun physical combat with their fellows, and develop a marked inferiority complex. The breasts are usually not full and the patients often not obese. The condition which develops after castration thus appears to be different from that of the Fröhlich syndrome, in which full breasts and the characteristic girdle type of obesity make their appearance. A condition exactly the same as that produced by castration early in life may develop when both testes fail to descend and remain within the abdominal cavity. Eunuchoidism, however, is by no means an invariable result of bilateral failure of testicular descent. While the intra-abdominal testis is never capable of producing spermatozoa, it may produce a variable degree of male sex hormone as judged by the development of a normal sized penis, some pubic and axillary hair and normal muscles and skeleton. While some production of male sex hormone is rather common in such cases, the development of a eunuchoid state is the most common result.

When loss of testicular function occurs after puberty as a result of castration, inflammation or trauma, the clinical picture produced is slightly different. The genitalia show varying degrees of atrophy, but remain much larger than they were before puberty. Some loss of hair occurs in the axillary and pubic regions and on the face, trunk and extremities, but the loss is rarely complete. The voice may become slightly higher pitched, but it does not revert to its prepubertal state. Impotence commonly, but not invariably results. The individuals affected become weak and apathetic and may have periods of worry, irritability and depression and suffer from hot flashes, just as some females do at the time of the menopause. As previously pointed out, the testes of some old men, although not diseased, appear to show some waning of function, which produces in milder form the symptoms that follow castration.

In the conditions just described the testis usually is incapable of responding to stimulation, either because of removal, destruction or improper environment. It is, therefore, necessary to supply artificially the male sex hormone which the testis is incapable of producing. Fortunately, testosterone propionate is a very potent product, but it is necessary to use it in adequate doses.

For most therapeutic purposes it is impractical to use concentrations of less than 25.0 mgm. per c.c. Our conclusions[6] are based on observations with the material of the Schering Corporation (Oreton).† The value of this material is well illustrated in eunuchoid individuals.

†Kindly supplied by Drs. Stragnell and Gilbert.

Effect of Testosterone Propionate

In a dose of 50.0 mgm. per day it produces the following changes in such patients in the course of from four to six months:

Development of secondary sexual characteristics. The penis may become as large as that of a normal adult, although its development is usually not quite as satisfactory as this. The scrotum enlarges and the prostate, which is commonly not palpable before treatment, usually develops until it becomes from 2.5 to 3.0 cm. in diameter and is raised from 0.2 to 0.3 cm. above the level of the rectum. Hair develops all over the body including the pubic and axillary regions and the face. Erections, masturbation and nocturnal emissions become frequent. The pitch of the voice rapidly becomes typically masculine.

A marked increase in appetite and gain in weight amounting to as much as 40 pounds in four months.

An associated marked increase in the size and firmness of muscles, which assume the characteristics of the normal adult male, whereas in the eunuchoid state they resemble those of the female. This physical change is associated with a marked increase in mental acumen. The patients are capable of and have the initiative to do much more physical and mental work.

A marked emotional change. The patients develop self-confidence and a determination to seek and defend their rights. Their effeminate characteristics disappear.

A temporary increase in basal metabolism of as much as 30 per cent in some patients.

Since the loss of testicular function in eunuchism and eunuchoidism is permanent, treatment will probably have to be continued throughout life, although after the desired changes have been produced it may be possible to maintain them with smaller doses. What the dose for maintenance will prove to be is still to be worked out. It is desirable to begin treatment at the age of ten to twelve years in order to avoid the skeletal changes which develop when lack of male sex hormone persists during the age of normal puberty.

The Male Climacteric

There appears to be some waning of testicular function in later life, the extent of which varies greatly in different men. There is no definite epoch in the male like the menopause in the female. In some males, however, there may develop a condition resembling the menopause in the female, characterized by the development in varying degree of the symptoms which follow castration (described above). In such individuals, testosterone propionate in a dose of 50 mgm. three times a week often produces striking improvement. Caution must be exercised, however, in treating old men with this material. The increase in body vigor which it produces may tax the cardiac reserve and precipitate mild decompensation: and the increase in the size of the prostate which it induces may aggravate latent benign prostatic hypertrophy.

Impotence

The problem of impotence is a complex one. Psychic factors play an important rôle in many cases. If these are excluded and a definite glandular origin established as in older men whose testicular function, previously good, is beginning to wane, then glandular therapy may produce improvement. This may be of the substitution or of the stimulation variety, depending upon the capacity of the testis to respond. To be specific, testosterone propionate may be used if the testis is incapable of responding, and the gonadotropic material from the urine of pregnant women, if it is capable.

Benign Prostatic Hypertrophy

This is a common disorder and occurs to some extent in four out of ten men after the age of 60. Various observers have reported improvement in this condition from the use of the male sex hormone. This is difficult to understand because of the following considerations:

Production of male sex hormone is responsible for the development of the prostate.

Castration and atrophy of the testes produce atrophy of the prostate.

Development of the prostate can be produced in eunuchs and in eunuchoid individuals by administration of testosterone propionate, and in normal young boys by administration of this material or gonadotropic factor from the urine of pregnant women.

Benign prostatic hypertrophy occurs at an age when the production of male sex hormone is supposed to be reduced.

Heckel and Thompson[6] have been unable to produce any improvement in 22 patients with

benign prostatic hypertrophy during the administration of testosterone propionate. Some of the men felt slightly more energetic while taking it but there was no reduction in residual urine or improvement in any other abnormality related to the prostatic hypertrophy.

Testosterone propionate is a very important therapeutic agent, but, like many other potent products, has been used in a variety of conditions in which there is no specific indication for its use. The chief indication for its use is loss of testicular function, primarily in patients whose testes are incapable of responding to stimulation. Testosterone propionate injures the normal testis temporarily, as judged by a marked reduction in the spermatozoa count during its administration.[3] It is, therefore, probably desirable to use stimulation rather than substitution therapy whenever the testis is capable of responding to stimulation.

SECONDARY HYPOGONADISM

Hypopituitarism and the Fröhlich Syndrome

A very common disorder associated with hypogenitalism is the Fröhlich syndrome, which is also characterized by obesity and in the more marked forms by a low basal metabolism. The obesity is most marked in the trunk and thighs, the forearms and lower legs often being normal in size. In males the shoulders are narrow, the breasts full and the hips broad, creating a feminine contour. The excess abdominal fat hangs down in an apron over the pubic region, producing a characteristic transverse fold in the lower abdomen. Genu valgum is almost always present. There is often a maxillary prognathism in contrast to the mandibular prognathism of acromegaly. In most cases no enlargement of the sella turcica is noted, although the case originally described by Fröhlich was associated with a craniopharyngioma. It has been pointed out by Bauer[1] that some fat boys of this type develop a more or less normal body contour without treatment as sexual maturity sets in. It has been our observation, however, that in many, if not most, of them physical and sexual development do not become normal. There appears to be little doubt that hypopituitarism is present in patients of the Fröhlich type, but the cause of the obesity is obscure. It may be related to a disturbance in the base of the brain above the pituitary.

In patients who develop chromophobe adenomas and craniopharyngiomas of the pituitary early in life, the Fröhlich syndrome may develop with or without dwarfism and sexual maturity may fail to occur. When such tumors develop after puberty they may produce a syndrome related to that of Fröhlich with genital atrophy, girdle type of obesity and low basal metabolism. Obesity, however, is not an invariable result of such tumors or of hypopituitarism from other causes. In the most marked form of hypopituitarism, as, for example, that seen in Simmonds' disease, cachexia and loss of weight are associated with hypogenitalism.

The ideal form of treatment in the Fröhlich syndrome and other forms of hypopituitarism would be the administration of a pituitary preparation containing the gonadotropic factors and other principles necessary to correct the associated pituitary deficiencies. From a practical standpoint, however, the effect of pituitary extracts is too uncertain to warrant their routine clinical use.

The best gonadotropic material to use at the present time is that prepared from the urine of pregnant women (A.P.L., Follutein, Korotrin, Pranturon, Antuitrin-S, et cetera). This should be given in a dose of from 500 to 2,000 rat units daily (as much as 5,000 rat units daily in older patients) and treatment should be started about the age of ten or eleven years and kept up beyond the age of normal puberty in order to avoid the skeletal changes which result without treatment. Response to treatment is by no means absent after the age of puberty, however, as is illustrated by production of marked genital growth in a man thirty-seven years old during the daily administration of 2,500 to 5,000 rat units of A.P.L. If given sufficiently early, the treatment may alter the skeletal configuration and by increasing activity, produce some reduction in weight. However, it is almost always necessary to administer a suitable weight-reducing diet and, in patients with a low basal metabolism, a dose of thyroid sufficient to raise the rate to normal.

Undescended Testes

Observations of the last few years by many workers appear to indicate that failure of descent of the testis may be caused in two ways:

By lack of normal stimulation which is necessary for descent.

By anatomic abnormalities of any of the parts involved in descent.

The hormonal factors involved in descent are not clearly understood. The influence of the anterior pituitary-like principle and its high concentration in the urine of pregnant women suggest that it may play some rôle normally in the descent of the testis during fetal life. We have been unable to corroborate the high incidence of successful results reported by many observers in the glandular therapy of undescended testes (60 per cent on the average). We have, in fact, been able to produce descent in only 20 per cent of all the cases and in only 27 per cent of those in patients under sixteen years of age.[7] The difference between our results and those of most observers may be accounted for in part by our exclusion, except in the beginning of the study, of all testes of the migratory or retracted types.

Our observations have led us to conclude that the anterior pituitary-like principle of pregnancy urine causes descent only of those testes not retained by mechanical factors. The same testes which descend as a result of treatment would probably descend at the time of puberty without treatment. If no more is accomplished with treatment in young boys than is accomplished by natural processes at a later age, then we must inquire whether the treatment is worthwhile. The crux of the problem is whether a testis made to descend at an early age with treatment is more likely to be normal than one which descends later without treatment. Since the testis normally descends into the scrotum during the last month of fetal life and since it can not function normally unless it is in the scrotum, it appears probable that in true cryptorchidism the testis should be made to descend at the earliest possible age.

The advantages of glandular treatment are:

It produces descent in some patients.

It makes it possible to determine at an early age in what cases descent is prevented by mechanical factors necessitating operative interference.

By enlarging the parts involved, it appears to facilitate subsequent operative procedures.

If treatment is properly carried out, it does not appear to produce any harmful effects, but it should be emphasized that little is known about the influence of premature stimulation with this material on the function of the testis after puberty. If the treatment is carried too far, excessive genital growth may result, giving rise to a condition simulating premature puberty. The material of choice is the anterior pituitary-like principle of pregnancy urine, previously referred to. This acts by stimulating the interstitial cells of the testis to produce more male sex hormone. The same result may be produced by the administration of male sex hormone itself, but since, as already pointed out, this may injure the normal testis, the stimulation type of therapy is to be preferred.

The treatment should probably be started at the earliest age at which operation is feasible if treatment is not effective. Just what this age is is a matter for debate.

It can certainly be carried out as early as the age of three years. The dose in most young boys varies from 100 to 1000 rat units daily for a period of from two to six months. If descent occurs, the treatment may be discontinued. In successful cases this usually takes place within two months. If descent does not occur within this time, treatment should be continued until a moderate amount of genital growth occurs, care being taken to avoid excessive growth. If the testis still fails to descend, operative procedures should be resorted to at once. If any delay ensues between the time that glandular therapy is discontinued and operative procedures started, some regression may take place in the size of the genitalia, thereby increasing the difficulty of operation. In the majority of cases, ideal treatment, therefore, involves the intelligent combination of medical and surgical measures. In some instances in which difficulty is encountered in bringing the testis to a sufficiently low level at the time of operation, glandular therapy may be valuable in the postoperative period.

Summary

Hypogenitalism may be primary or secondary in type. The primary type is seen after castration, after destruction of the testis by inflammation or trauma, and following lack of development, sometimes associated with bilateral failure of descent from the abdominal cavity. The secondary type is seen in patients with hypopituitarism including the Fröhlich syndrome, and in some patients with undescended testes.

In primary hypogenitalism stimulation therapy with male sex hormone (testosterone propionate) is indicated, and in the secondary type substitution therapy with suitable gonadotropic principles.

In doses of 50.0 mgm. per day testosterone propionate produces striking improvement in eunuch and eunuchoid individuals. It may also produce marked improvement in certain cases of the male climacteric associated with waning testicular function, but is of no value in benign prostatic hypertrophy.

In cases of impotence associated with decrease in testicular function, improvement may be produced either with stimulation or substitution therapy depending upon the capacity of the testis to respond. The problem of impotence is a complex one and care must be taken to exclude psychic causes.

In patients with the Fröhlich syndrome, striking improvement may be produced by the use of large doses of gonadotropic material from the urine of pregnant women. This material is also of value in the treatment of undescended testes. It may produce descent or may aid subsequent operative procedures by enlarging the parts involved. Patients receiving this form of treatment must be followed with great care in order to avoid the production of excessive genital growth.

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THE B_2 COMPLEX

In the field of the vitamins, the B_2 complex remains an outstanding challenge to scientists. The fact that the term "complex" still is applied to the B group is sufficient evidence that its complexities have not as yet been clarified. Nevertheless, in the routine practice of medicine, it generally is not realized that the ramifications of this group of vitamins are so widespread in their effects on human metabolism that only the surface has been scratched; and it is all too frequent that vitamin B therapy is prescribed with no regard to the action of its various components. This is largely the result of the grouping of the B factors under the term "vitamin B," even though there is no chemical relationship among them and their physiologic actions are different. Quoting Dameshek and Myerson[1] "the situation in regard to recognition and purification of the various factors of the B_2 complex shows such rapid change that a publication of even a year ago is now outdated."

B_1, or thiamin chloride, has been isolated in pure form and its antiberiberi effect definitely established. Riboflavin, or lactoflavin, commonly known as vitamin B_2, has been chemically identified and constitutes an important component in the oxygen reduction mechanism of the body cells. Its deficiency in the body may result in an erosion of the mucous membrane and a cracking of the squamous epithelium at the corners of the mouth,[2] and in experimental animals its deficiency will cause growth disturbances, yellow liver, and cataract. Deficiency of the nicotinic acid in this B group has been established as the main cause of pellagra,[3] and its chemical formula is also established. But of the other factors in the complex, B_3, B_4, B_5, and B_6 identified by Gyorgy,[4] and the filtrate and W factors, but little is known. Besides these, others that may or may not have a vitamin activity, factors such as choline and the gray-hair preventive factor of Lunde and Kringstad are as yet undetermined in regard to their need and their therapeutic value.

For the clinician, therefore, it would seem that, for the present at least, treatment of vitamin B deficiencies would be best carried out by giving the patient the entire B complex, instead of only the known factors whose potency has more or less been determined. These latter can be added in the required amounts.—*New York State Journal of Medicine*, May, 1940.

[1]Dameshek, W., and Myerson, P. G.: Am. J. M. Sc., 199:518, (Apr.) 1940.
[2]Sebrell, W. H., and Butler, R. E.: Pub. Health Rep., 53:2282 (1938).
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EDITORIAL

INFLUENZA

■ THE WARNING by medical columnists that an epidemic of influenza may be expected this winter should awaken more than a passing interest by the physician in spite of the tremendous tension of a war-torn world.

Last winter, particularly in the South, there was a marked increase in the cases of influenza reported. A review of the 1889-1892 and 1918-1920 pandemics provides some basis for expecting a second wave here this coming winter. If this increase of last year was a first wave then this coming second wave will hit with more severity in a wider scope.

Since 1918 we have come to accept the etiology of influenza as a filterable virus. In spite of the intensive and splendid research we are still in some doubt as to the identity of this virus or these viruses, since it is believed by certain research men that there is not a common offending virus.

The usual warning, the scattered case, is often too mild to occasion much alarm and is frequently ignored until the multiplicity of contacts bring on the sudden catastrophe of a major epidemic. The very mildness of the initial cases and the short incubation period are important factors in this tidal wave which almost threw the country into a panic in the years of the last war.

We have as yet no satisfactory vaccine or drug therapy and most of the success in preventing a cataclysm must lie in preventive measures. Urging the patient to seek isolation early, which is best accomplished by making him a bed patient, may break this malicious chain of infective contacts.

The discovery of sulfanilamide and its related compounds may have opened the field of chemotherapy which will modify the attack, but until then, the attitude of the physician must be that of a health officer in urging quarantine to the early cases which he sees.

TELL THEM

■ ONE of the major nuisances of the medical profession is the indiscriminate use of the title "Doctor" by various technicians, cultists and practitioners of limited branches of the healing art who have not attempted to satisfy the usually accepted amount of education to deserve the use of the title, Doctor.

One solution was made the topic of an editorial in THE JOURNAL recently and that suggestion may go a long way to aid. It is pleasing, at this time, to note that the Michigan State Board of Registration in Medicine through its secretary, J. Earl McIntyre, M.D., has been carrying on a quiet but persistent campaign to erradicate some of the obnoxious offenders. This has, in the main, been done through presenting the several opinions of attorneys general to the various agencies which are the media through which the use of the title is made. From copies of the correspondence between newspapers and telephone companies and the Board, the response has been gratifying.

In the State of Michigan it is clearly illegal for optometrists, chiropractors and naturopaths to call themselves doctors without qualification. If your local newspaper or telephone company is acquainted with this fact and if it is a medium of a higher type, coöperation will be easily obtained. Only a few desire to evade the intent of the law if they are acquainted with the facts. Tell them!

HELP FROM THE DRUGGISTS

■ A LIAISON recently effected with the Michigan State Pharmaceutical Association seems of far greater value than would be indicated by the comment it received. Drs. C. K. Valade and R. S. Breakey of the Syphilis Control Committee of the Michigan State Medical Society obtained from the convention group a splendid resolution of coöperation with the Michigan State Medical Society in the handling of venereal disease.

Dr. Valade speaking on the subject, "Venereal Disease Control As It Affects Pharmacy" presented a simple, straight-forward, honest exposition of the pharmacist's part in this program to erradicate syphilis and gonorrhea. The reaction of the association fully demonstrated the high calibre of its members and its interest in maintaining and advancing coöperation with the phy-

sicians. They adopted a seven-point resolution which is fully worth re-reading:

WHEREAS, in our desire to coöperate with the State Medical Society

BE IT RESOLVED that the Michigan State Pharmaceutical Association urges all its members to assist the health and welfare forces in the community in the conquest of Syphilis and Gonorrhea by making the following seven principal contributions:

First, Don't diagnose.

Second, Don't prescribe.

Third, Refer patients to the physician.

Fourth, Don't sell patent remedies for self-treatment of venereal diseases.

Fifth, Don't sell defective prophylactics.

Sixth, Distribute informational literature obtainable from health departments concerning syphilis and gonorrhea.

Seventh, For the Michigan State Pharmaceutical Association to give valued help as a body of professional men.

It is safe to say that other groups interested in protecting the health of the people are anxious to offer coöperation in any of our programs. The main requirement is that the information be offered to them in like manner and the legitimate forces which purvey health may be consolidated against the unscrupulous cults, irregulars and their parasites.

The Syphilis Control Committee has set an example for similar committees to follow.

NATIONAL PHYSICIANS COMMITTEE

■ THE National Physicians Committee has been sponsoring some very excellent medical publicity through an advertising campaign paid for by local physicians or allied interested stores or individuals. This is the type of work which will be our mainstay in interesting the public in the dangers of state controlled medicine and in the necessity of preserving our individual liberties.

If the Committee does nothing else but this it will have been well worth its organization. However, the extent of their service has gone far beyond this contribution, and its useful contacts with other groups and individuals may establish the balance necessary for our continued medical freedom.

FREE—

■ Do YOU want a concise, authentic, handy pamphlet on "Immunization and Diagnostic Procedures?" It will not cost you a cent. If you have not already received it you will shortly. The Michigan Department of Health is sending it to you and it has been approved by the Academy of Pediatrics (Michigan Branch), by the Michigan State Medical Society and, of course, by the Department of Health.

Included with the pamphlet you will find a sample immunization card which will be furnished you to give to each patient as a permanent record of his protection against contagious disease.

Every physician should be a health officer.

YOUR NEW PRESIDENT

Paul R. Urmston, of Bay City, known to his many friends as "Pru," became President of the Michigan State Medical Society at the annual meeting in Detroit, succeeding Burton R. Corbus. For many years Dr. Urmston has played a most important part in the Executive Committee of the Council of the Michigan State Medical Society. Afraid of no one, possessed of his proven faith in the profession and willingness to sacrifice his personal enjoyment for the betterment of the Michigan State Medical Society, he will undoubtedly be one of the most popular Presidents the society has ever had. His ability to appreciate every angle of a problem and every difference of opinion, and yet retain the courage of his convictions, which is sufficient to make decisive changes when necessary, prophesies well for the advance of the society during the next year. His selection of committees was so well done that there was not a single objection from the Council to the entire list of one hundred thirty-six committeemen who will help carry on the work of the Michigan State Medical Society for the coming year.

IN THESE HANDS

At the meeting of the House of Delegates in September Henry R. Carstens of Detroit was elected President-elect after a most successful year as Chairman of the Council and a number of years as a member of that body. Among his many and varied types of leadership in the pro-

fession it is of particular interest that he is Governor of the American College of Physicians, for the State of Michigan. He has served on the Council of the Wayne County Medical Society, and been its President. He is the President of the Michigan Medical Service and possesses an enviable reputation as an internist.

Paul R. Urmston, M.D., Bay City
President, 1940-41

Henry R. Carstens, M.D., Detroit
President-Elect

A. S. Brunk, M.D., Detroit
Chairman of the Council

H. H. Cummings, M.D., Ann Arbor
Vice-Chairman of the Council

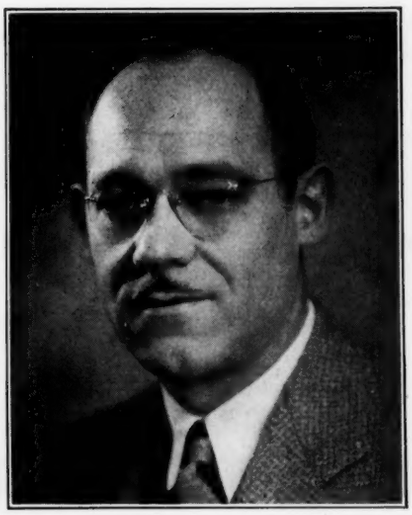
His fellow Councilor from Wayne County, A. S. Brunk, has been advanced from Vice Chairman to Chairman of the Council to succeed Dr. Carstens. He is also an ex-President of Wayne County Medical Society and his sound views on the practice of medicine have won him the respect of all his colleagues.

Howard H. Cummings, of Ann Arbor, who has been Chairman of the County Societies Committee, has been advanced to Vice Chairman of the Council. His cultural attainments and an unswerving faith in his profession and its members have turned his natural executive abilities into an invaluable aid to the Michigan State Medical Society.

Vernor Moore of Grand Rapids was continued as Chairman of the Finance Committee. This

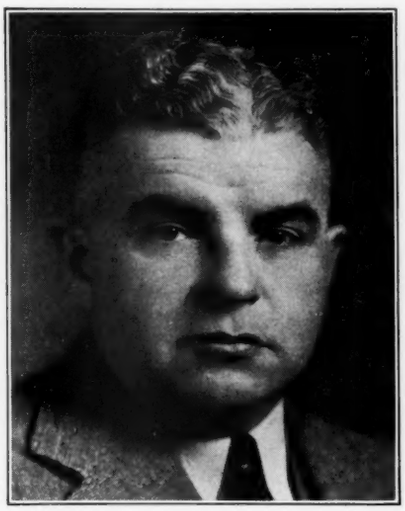
Vernor Moore, M.D., Grand Rapids, Chairman of the Finance Committee

Wilfrid Haughey, M.D., Battle Creek, Chairman of the Publications Committee

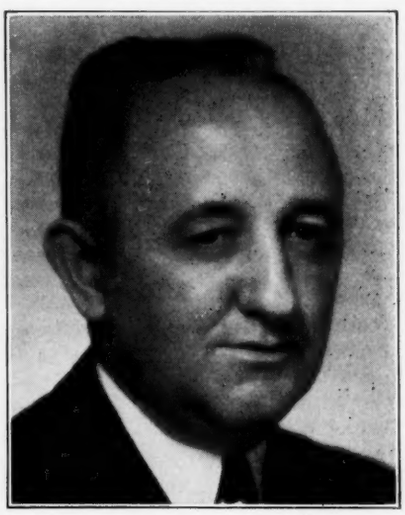


E. F. Sladek, M.D., Traverse City, Chairman of the County Societies Committee

Otto O. Beck, M.D., Birmingham, Councilor, Fifteenth District



Philip Riley, M.D., Jackson, Councilor, Second District



C. E. Umphrey, M.D., Detroit, Councilor, First District

Oscar D. Stryker, M.D., Fremont, Speaker of the House of Delegates

James J. O'Meara, M.D., Jackson, Vice-Speaker of the House of Delegates

never-ceasing watchdog of the treasury has been worth a great deal to the Society.

Wilfrid Haughey of Battle Creek, who has battled unceasingly against political and semi-political forces which attack our profession, has been re-named Chairman of the Publications Committee.

E. S. Sladek of Traverse City who was elected to the Council in 1937 had been the active secretary of the Grand Traverse County Society for a number of years and his intelligent consistent work singled him out as Councilor of the Ninth District. Continuing this type of leadership in the Council his qualifications were recognized by his colleagues and they unanimously elected him Chairman of the Committee on County Societies to succeed Dr. Cummings. The Council feels that he will be of great worth on the Executive Committee during this coming important year.

These five men together with the Speaker of the House of Delegates make up the Executive Committee of the Council which continues the arduous and all-important work of directing the work of the Michigan State Medical Society between meetings of the whole Council or of the House of Delegates. Our profession should indeed be safe in the hands of such outstanding men as these. Each man is organization-minded, hard-working and a leader in the profession.

Oscar D. Stryker, re-elected Speaker of the House of Delegates, was graduated from Calvin College with the degree of A.B. and he obtained his M.D. from Northwestern University. He spent an interneship at Grace Hospital, Detroit. Since 1929, he has been in general practice in Fremont. Dr. Stryker has been very active in civic affairs in Fremont, having served three terms as Mayor of the city and also as a member of the board of directors of the Chamber of Commerce. Dr. Stryker's able handling of the past session of the House and his splendid and faithful record as a member of the Executive Committee of the Council were outstanding.

James J. O'Meara of Jackson was reëlected Vice Speaker of the House of Delegates. Dr. O'Meara attended the University of Michigan and Northwestern University, graduating from the latter in 1911, after which he spent his interneship in Oak Park Hospital, Chicago. He began practice in Jackson in 1912, spent 1918-1919 in the Army. He returned to Jackson, where he has been in practice ever since. He is on the staff of Mercy Hospital and W. A. Foote Memorial Hospital.

NEW COUNCILORS

In the Third District, Wilfrid Haughey, of Battle Creek was reëlected to succeed himself. In the Fifteenth District, Otto O. Beck, who had been appointed to fill out the unexpired term of George Sherman, was reëlected to succeed himself. In the Sixteenth District, A. S. Brunk of Detroit was reëlected to succeed himself. In the Second District J. Earl McIntyre found that his duties as Secretary of the Michigan State Board of Registration took too much of his time and he refused to become "a third termite." An old worker of the Michigan State Medical Society was returned in the person of Philip Riley of Jackson who served two years as Vice Speaker and two years as Speaker of the House of Delegates. He will undoubtedly provide the Second District with able direction and representation. Due to the resignation of Henry Carstens from the Council, C. E. Umphrey of Detroit was elected in his place. Dr. Umphrey, though a new-comer to the Council, is no stranger to the activities of organized medicine. He has been one of the leaders of the profession in Wayne County and has been very active in the House of Delegates for many years. His professional and cultural attainments are such that he is being drafted for service in organized medicine. These qualities, combined with his pleasing personality, indicate that the wider spread of his services will be of increased worth to the profession. The state profession is indeed in good hands.

WAR DEPARTMENT
ARMY MEDICAL LIBRARY
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October 21, 1940.

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President's Page

Your Medical Preparedness Questionnaire

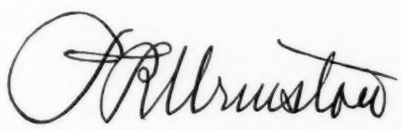
IN ASKING every physician to send in a Preparedness Questionnaire, the American Medical Association is performing the task that rightfully belongs to the Profession, and not to some governmental agency.

Mistakes made in the last World War, such as depleting whole counties of doctors, will not be repeated—if all physicians will coöperate in mailing their Questionnaires to Chicago.

The medical profession will know what physicians are best suited to enter military service, to teach, to stay in practice, and to offer aid in the very essential civilian service, such as Industrial Health.

The distinct advantage to each physician will come from proper classification, as he will be assured of careful consideration of his family obligations, the need for his services in his own community, and his personal fitness for particular service.

Send in your Preparedness Questionnaire today. Let the medical profession be its own judge in Medical Preparedness.



President, Michigan State Medical Society.

MICHIGAN MEDICAL SERVICE

PROMPT payments to doctors for services rendered is one of the advantages of the medical service plan. However, late or incomplete reports make it impossible for M.M.S. to pay doctors promptly. One of the chief problems in the first several months of operation has been the failure on the part of physicians to send *Monthly* Service Reports promptly or to send completed reports. It will be to the advantage of all concerned—the patient, the doctor and the medical service plan—if doctors and their office assistants will become better acquainted with the procedures for billing Michigan Medical Service for services rendered subscribers.

Billing by Doctors

The medical service plan requires only a minimum of paper-work. First, the doctor sends a short Initial Service Report to verify that the patient is in good standing and entitled to benefits for the services requested. Second, a Monthly Service Report itemizing the services rendered is sent to Michigan Medical Service as the bill for payment.

When the patient identifies himself as a subscriber to Michigan Medical Service by presenting his Identification Card or his Certificate, it is necessary for the doctor to know whether the subscriber is entitled (a) to full services of the Medical Service Plan or (b) to the partial services of the Surgical Benefit Plan. Hence, it is of real importance for the doctor to know the benefits and provisions of both plans. If there is any doubt in the doctor's mind as to whether or not the service would be a benefit under Michigan Medical Service, the Initial Service Report indicating the services to be rendered will bring a prompt notice from Michigan Medical Service whenever services requested are not properly benefits under either plan.

At the completion of services, but *not later than the end of each month,* the Monthly Service Report should be sent to Detroit for the attention of the Medical Advisory Board. To avoid delay in the approval of this bill for services, all information requested should be filled in as completely as possible. The Medical Advisory Board will be assisted greatly if the doctor sending the report will indicate the amount of special services he has rendered such as the extent of lacerations sutured; the location, size and type of tumor or cyst removed; the particular type of operation performed (Sturmdorf, Baldy-Webster, Caldwell-Luc); and the kind of x-ray (chest, stereoscopic). A revised Monthly Service Report embodying many improvements gained by actual experience is now ready for use and will make reporting even more simple for the doctor.

After the completed Monthly Service Report

MICHIGAN MEDICAL SERVICE REGISTRATION HONOR ROLL

(As of October 10, 1940)

100 Per Cent

Barry
Mason

90 to 99 Per Cent

Manistee
Menominee
Monroe
Newaygo
Tuscola

80 to 89 Per Cent

Allegan
Bay-Arenac-Iosco-Gladwin
Calhoun
Chippewa-Mackinac
Clinton
Delta-Schoolcraft
Dickinson-Iron
Gratiot-Isabella-Clare
Hillsdale
Ingham
Kent
Lenawee
Mecosta-Osceola
Midland
Oceana
Ontonagon
Saginaw
St. Joseph

75 to 79 Per Cent

Branch
Eaton
Lapeer
Muskegon
Northern Michigan
North Central Michigan
Ottawa
Wexford-Kalkaska-Missaukee

is sent to Michigan Medical Service, the doctor should make certain that a bill is not also sent by his office to the patient. The sending of a bill to the patient causes confusion. If the patient is a subscriber to Michigan Medical Service with an income below the limit of $2,000 for the Individual Certificate or $2,500 for Husband and Wife or Family Certificate, no bill should be sent to the patient for services, which are to be paid in full by Michigan Medical Service. However, in the event the patient is a subscriber whose income is above the limit, the statement which is returned with the check by Michigan Medical Service will indicate that the payment is to apply as a credit. The doctor may then send a bill to the patient for the difference, if any, between the payment received from Michigan Medical Service and the charge which he would customarily make to the patient.

Annual Meeting of Michigan Medical Service

The first Annual Meeting of the members of the corporation of Michigan Medical Service was held Wednesday, September 25, 1940, in Detroit. A full report of the operation of Michigan Medical Service was presented to the members who are the Delegates of the Michigan State Medical Society and the Board of Directors of Michigan Medical Service. Members of the corporation were generous in their praise of the work done by the officers and committees. An enlarged Board of Directors was elected and all officers and members of the several committees were re-elected.

Statistics

As of September 30, 1940, 69,316 subscribers were enrolled. A total of 3,257 doctors of medicine are registered with Michigan Medical Service, representing three-fourths of the practitioners in the state. A total of 3,562 patients received service in the first seven months, with benefits to doctors in excess of $145,000. One out of every six physicians in Michigan has been paid through M.M.S. From the beginning, the full schedule of benefits has been paid to co-operating physicians. The operation of M.M.S. has been accomplished with a minimum of expenditure for administration expenses.

PROCEEDINGS OF HOUSE OF DELEGATES—1940

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MICHIGAN STATE MEDICAL SOCIETY

Seventy-fifth Annual Meeting

Proceedings of House of Delegates

Book-Cadillac Hotel, Detroit, Michigan

September 24, 1940

Tuesday Morning Session

September 24, 1940

The First Session of the 75th Annual Meeting of the House of Delegates of the Michigan State Medical Society, held in the Grand Ball Room of the Book-Cadillac Hotel, Detroit, Michigan, convened at nine twenty-five o'clock, O. D. Stryker, M.D., of Fremont, the Speaker, presiding.

THE SPEAKER: The meeting will please come to order.

Is the Chairman of the Committee on Credentials ready to report?

E. O. Foss, M.D.: There are 86 accredited delegates here out of a possible 107.

THE SPEAKER: That constitutes a quorum, so the First Session of the House of Delegates is now officially open.

RECORD OF ATTENDANCE

	COUNTY	DELEGATE	Session 1st	2nd	3rd
1.	Allegan	O. H. Stuck	x	x	x
2.	Alpena-Alcona-Presque Isle	W. E. Nesbitt	x	x	x
3.	Barry	R. B. Harkness	x	x	x
4.	Bay-Arenac-Iosco-Gladwin	C. L. Hess	x	x	x
		Fred Drummond	x	x	—
5.	Berrien	Wm. Ellet	x	x	x
6.	Branch	R. L. Wade	x	x	x
7.	Calhoun	A. T. Hafford	x	x	x
		Harvey Hansen	x	x	x
8.	Cass	S. L. Loupee	x	x	x
9.	Clinton	Not represented			
10.	Chippewa-Mackinac	B. T. Montgomery	x	x	x
11.	Delta-Schoolcraft	Not represented			
12.	Dickinson-Iron	W. H. Alexander	x	x	x
13.	Eaton	Paul Engle	x	x	x
14.	Genesee	F. E. Reeder	x	x	x
		Geo. J. Curry	x	x	x
		D. R. Brasie	x	x	x
		Henry Cook	x	x	x
15.	Gogebic	Not represented			
16.	Grand Traverse-Leelanau-Benzie	B. B. Bushong	x	x	x
17.	Gratiot-Isabella-Clare	M. G. Becker	x	x	x
18.	Hillsdale	Luther W. Day	x	x	x
19.	Houghton-Keweenaw-Baraga	J. H. Kirton	x	x	x
20.	Huron-Sanilac	C. W. Oakes	x	x	—
21.	Ingham	C. F. DeVries	x	x	x
		R. S. Breakey	x	x	x
		T. I. Bauer	x	x	x
22.	Ionia-Montcalm	W. L. Bird			
23.	Jackson	P. A. Riley	x	x	x
		J. J. O'Meara	x	x	x
24.	Kalamazoo	F. M. Doyle	x	x	—
		L. W. Gerstner	x	x	x
25.	Kent	A. V. Wenger	x	x	x
		C. F. Snapp	x	x	x
		A. B. Smith	x	x	x
		G. H. Southwick	x	x	x
		P. W. Kniskern	x	x	x
26.	Lapeer	D. J. O'Brien	x	x	x
27.	Lenawee	A. W. Chase	x	x	—
28.	Livingston	D. C. Stephens	x	x	x
29.	Luce	Henry E. Perry	x	x	x
30.	Macomb	D. Bruce Wiley	x	x	x
31.	Manistee	E. A. Oakes	x	x	x
32.	Marquette-Alger	V. Vandeventer	x	x	x
33.	Mason	Not represented			
34.	Mecosta-Osceola-Lake	G. H. Yeo	x	x	x
35.	Menominee	H. T. Sethney	x	x	—
36.	Monroe	D. C. Denman	x	x	x
37.	Midland	Ed. H. Meisel	x	x	x
38.	Muskegon	E. O. Foss	x	x	x
		E. N. D'Alcorn	x	x	x
39.	Newaygo	O. D. Stryker	x	x	x
40.	No. Michigan (Antrim, Cheboygan, Emmet, Charlevoix)	Wm. S. Conway	x	x	
41.	Oakland	Richard Olsen	x	x	x
		C. T. Ekelund	x	x	x
		Geo. A. Sherman	x	x	x
42.	Oceana	Merle G. Wood	x	x	—
43.	O.M.C.O.R.O.	C. R. Keyport	x	x	x
44.	Ontonagon	Wm. F. Strong	x	x	x
45.	Ottawa	A. E. Stickley	x	x	x
46.	Saginaw	C. E. Toshach	x	x	x
		S. A. Sheldon	x	x	x
47.	St. Clair	A. L. Callery	x	x	x
48.	Shiawassee	A. L. Arnold, Jr.	x	x	x
49.	St. Joseph	R. A. Springer	x	x	x
50.	Tuscola	T. E. Hoffman	x	x	x
51.	Van Buren	E. Terwilliger	x	x	x
52.	Washtenaw	J. A. Wessinger	x	x	x
		Dean W. Myers	x	x	x
		L. J. Johnson	x	x	x
53.	Wayne	R. H. Pino	x	x	x
		R. L. Novy	x	x	x
		E. D. Spaulding	x	x	x
		J. M. Robb	x	x	x
		T. K. Gruber	x	x	x
		J. A. Kasper	—	x	x
		H. F. Dibble	—	x	x
		A. E. Catherwood	x	x	x
		W. B. Cooksey	x	x	—
		Wm. J. Stapleton, Jr.	x	x	x
		R. M. McKean	x	x	x
		Henry A. Luce	x	x	x
		R. C. Jamieson	x	x	—
		C. S. Kennedy	x	x	—
		G. C. Penberthy	x	x	x
		L. J. Hirschman	x	x	x
		G. S. Bates	x	x	x
		C. E. Umphrey	x	x	x
		C. E. Dutchess	x	x	x
		H. W. Plaggemeyer	x	x	—
		C. E. Simpson	x	x	x
		Allan McDonald	x	x	x
		H. J. Kullman	x	x	x
		P. L. Ledwidge	x	x	x
		C. K. Hasley	x	x	x
		L. W. Hull	x	x	x
		A. F. Jennings	x	x	x
		G. L. McClellan	x	x	x
		C. F. Vale	x	x	x
		L. T. Henderson	x	x	x
		Wm. S. Reveno	x	x	—
		C. K. Valade	x	x	x
		S. W. Insley	x	x	x
		C. F. Brunk	x	x	x
		R. V. Walker	x	x	x
		H. L. Morris	x	x	x
54.	Wexford	Not represented			

The Speaker read the list of the Reference Committees, as printed in the Handbook.

J. J. O'Meara, M.D., of Jackson, Vice Speaker, took the chair.

I. Speaker's Address

Mr. Vice Speaker, Members of the House of Delegates, and Officers of the Michigan State Medical Society:

It is a great honor to have the privilege of presiding over this important meeting, our Diamond Anniversary, of the House of Delegates today.

I wish to welcome you all to this meeting. Many of you have had the opportunity of being delegates for many sessions, but for others of you this is your first meeting. I am sure that the proceedings and deliberations of this session will be an inspiration to you.

The opportunity we have of serving organized medicine must be looked upon as a rare privilege, and one we should cherish to the utmost. Here we have representative government and democracy at its best, and I have no doubt but that by the end of this meeting we will have the satisfaction of a work well done and the knowledge that the Michigan State Medical Society will continue in its leadership in American medical policies. That it does continue to do so depends not so much upon its officers, or the council, but the responsibility is directly on you, for you are the chosen representatives of the rank and file of society membership.

At the 74th Annual Meeting held last year certain definite matters were referred by the House of Delegates to the Council for action. I wish to report on these matters at this time. In all things the Council was most coöperative with the wishes of the House and did their utmost at all times to follow your instructions.

The House of Delegates accepted with thanks the report of the Council on Michigan Medical Service and empowered the Council to complete the present plan and place it in operation. What has been done in this matter is, I know, common knowledge to all of you present as it is presented to you in the "Report of the Council"; however, I cannot help but take this opportunity of reminding you of the great success which has already been met with in this plan. By September first there were 64,449 subscribers with 44 different groups enrolled. During the first 6 months services were provided for more than 3,000 subscribers, with payments to doctors amounting to $125,000. The plan has attracted a great deal of favorable attention from other progressive state societies and is being used as a model in the formation of plans of their own. The Speaker at this time wishes to pay tribute to the Board of Directors and especially the Executive Committee of Michigan Medical Service for their untiring efforts in its development. It was necessary for them, again especially the Executive Committee, to meet two or three times a week during the first part of the formation in order to iron out all legal and administrative details so that the plan could be in operation as soon as possible.

The House of Delegates also instructed the Council to make a detailed study as to the need for a fund for the aid of widows and orphans of deceased members. Work has been done on this and it is expected that a report of progress will be made during this session.

At the meeting of the House of Delegates of the American Medical Association held in New York during June of this year a Committee on Medical preparedness was established and in accord with this program Dr. B. R. Corbus was selected in charge of medical preparedness in the State of Michigan. It has been felt by medical as well as lay leaders, especially in view of what happened to countries with inadequate defenses who have been over-run by power-mad dictators, that an adequate preparedness is our best assurance of keeping out of European troubles and keeping such dictators from attacking our democratic institutions. I am sure that this House of Delegates, representing the medical profession of Michigan, will give this committee its unqualified support so that the sense of the resolution of Dr. Ralph Pino offered at the 1939 session may still guide us in our actions.

To many of us the question often arises as to the state of medical practice today, both nationally and as it affects us in our own problems. Those of you who were fortunate enough to attend the 1935 session of the House of Delegates held at Sault Sainte Marie heard Speaker Henry Luce give "The Clinical Viewpoint of a Very Sick Patient." Certainly, since that time the Michigan State Medical Society has done much to improve the condition of this patient, the practice of medicine, and the patient is now enjoying a stormy but satisfactory convalescence. What has been accomplished, however. must not in any way give us a false feeling of security or cause us to let up in any way in our efforts in further improving his condition. Changing times and circumstances bring up new foes and forces which will do their utmost to bring this patient into a state of relapse. It is to be hoped that after January of 1941 our patient's recovery will be more complete. This expected recovery depends upon the coöperation of you and your friends, in order to insure that friends of medicine and our democratic system of practice are put into office at the next election. Certainly those who have consistently worked against us and the welfare of the people of our state are not worthy of our support.

May I remind you again that we are the delegated persons to work with one another for the progress of organized medicine in our state. Therefore in our discussions today, it is hoped that each member may offer such constructive criticism as may be in his power to suggest or present.

THE VICE SPEAKER: The Speaker's address will be referred to the Committee on Officers' Reports.

Dr. Stryker resumed the chair.

THE SPEAKER: The next item of business is the President's Address. Burton R. Corbus, M.D.

II. President's Address

Members of the House of Delegates, Michigan State Medical Society:

An editorial in THE JOURNAL of the Michigan State Medical Society five years ago, written at the conclusion of some thirteen years of continuous service as an official of this Society, estimated the activities of the Society over a period of years, and suggested some of the lines which might be followed in the future. This privilege is one that comes to me again as your retiring president. In this editorial I expressed my appreciation of the opportunity that has been accorded me to contribute a mite to the development of organized medicine in this state. I am most appreciative of this further honor and the opportunity to again serve you.

Michigan Medical Service

In estimating the activities of this past year I have no difficulty in placing the initiation of Michigan Medical Service as foremost in importance. You do not need to be reminded of the many years of discussion and planning, and the arguments pro and con which necessarily preceded the time when it finally went into operation. That this prepayment plan for medical service was something of a sociological as well as an economic experiment, was fully recognized by this House of Delegates when it directed its officers to proceed with the plan, and I congratulate you on your foresight and your courage. I know that you could not possibly have anticipated the mountain of work that your action placed upon the shoulders of your officers and your committee.

You asked that a plan might be devised to provide adequate professional care for the low income group, retaining the free choice of physician, and those fundamental and traditional ethical aspects which are necessary in the practice of medicine if medicine is to remain an honorable profession. It was recognized that the charge for professional service must be within the possibilities of the lower income group, and yet high enough to satisfy the reasonable requirements of the attending physician. Your committee had no satisfactory trail to follow. No existing plan conformed to your desires. Working in a new field it is remarkable that the product has been so satisfactory. There probably are some snares and pitfalls within the plan as it now exists, but Michigan Medical Service is confident that they can be safely taken care of. So far Michigan Medical Service is on safe ground. Upward of 70,000 individuals are now getting either full or limited service, to the great satisfaction of both the patient and the doctor.

The mass of detail incident to the establishment of this plan was carried by just a few men, and I want to make special mention of them for their sacrifice in time and energy has been great. This is especially true of Doctor Carstens who, in addition to being chairman of the Council, carried the extra load of being chairman of the committee. He was ably assisted by his committee, Doctor Cummings, Doctor Haughey and Doctor Brunk, who met week after week in developing and getting the plan into operation. To them the thanks of this Society are due.

Committees

It has ever been my thought that there was a very special obligation for a physician to contribute his bit to the promotion of his profession. A few favored ones have the ability to make exceptional contributions to medical science. The contribution that most of us can make is to do our day's work well, and to help where we can to integrate the scientific knowledge into the day-by-day practice through the promotion of organized medicine. That the members of this Society desire to contribute is shown by the willingness of my appointees to serve on committees. Not a single man declined his appointment, and so far as I know, not a single man has failed to give of his best. I wish to take this occasion to thank the chairmen of every committee for the splendid work that they have done. On two occasions chairmen of committees went to Washington, at their own expense, in the interests of a committee activity. The results of this enthusiastic, loyal committee activity is shown well in the reports that will be presented to you.

The new committee on Heart and Degenerative Diseases, under the chairmanship of Doctor Herman H. Riecker, is commended for preparing a brochure, *"Uniform Classification of Heart Diseases,"* now in the press. The successful fight of Doctor Fred Miner, chairman of the Iodized Salt Committee, before the Drug and Food Division of the Federal Department of Health, is one of the high points in the service rendered during the year. Iodized salt will continue to be marketed and so labeled as to indicate its preventive value in the development of endemic goiter. The evaluation of the favorable results from the use of iodized salt in the diet of children has been a major activity of our Iodized Salt Committee. To those whose attention has not been called to it, it should be stated that health officials acknowledge it to be one of the outstanding prophylactic measures of modern times. There is many another committee which deserves special award. The Syphilis Control Committee, under Doctor Breakey, has to its credit a year of exceptional educational work, and the Industrial Health Committee, under Doctor Cook, deserves special mention for its work with the industries of the state. The Preventive Medicine Committee, under Doctor Geib, has maintained a valuable liaison with the State Department of Health. Active, as they have been now for many years, the Cancer Committee and the Maternal Health Committee have to their credit a year of many accomplishments. There is nothing that I need to say about the Committee on Postgraduate Education for you know, as well as I, that it sets a standard for postgraduate education in the country.

These are not the only committees which have fulfilled most excellently their obligations. Every committee has been active. Every chairman has done his work well, and to chairmen and committeemen alike, I express the appreciation of the Society and my very personal thanks for the part they have had in making this a most successful and productive year.

At your direction I invited representatives from the two medical schools to meet with a committee from this Society to discuss the matter of intern training and intern placement. Out of this meeting came a committee to be known as the Conference Committee on Prelicensure Education, with additional representation from the State Board of Registration and the Michigan Hospital Association.

Its first objective will be to develop a coöperative plan for intern training. The Committee recognizes the special advantages offered by some of the independent general hospitals. It also recognizes that the so-called teaching hospitals offer those special opportunities which fulfill the requirements for licensure by the specialty boards. It purposes to direct its efforts to working out some sort of a combined plan. I suggest that this committee be listed in THE JOURNAL, and that representatives from the Society be appointed to it, as in the case of the Joint Committee on Health Education.

Public Relations

"Not yet have we convinced the State," said one of our early presidents, "that our profession, unlike any other class in the community, is working against its own interest in striving for enactments which will prevent and cure disease." It has been many years since this was written, and today the public is but little more inclined to credit organized medicine with altruistic objectives. It recognizes, but it takes for granted, our efforts directed to lay education, to disease prevention, and to health projects of various sorts. It is expected of us that we shall be interested in all social betterment projects. A campaign of misrepresentation, even villification, directed against us by those who desire a form of social-political control of medicine, finds a public not unresponsive.

As far back as the sixteenth century government recognized the need for restrictive laws to control the practice of the healing art as a protection for its citizens against the charlatan and the incompetent. In so doing it unavoidably sets up a privileged class. There are benefits accruing to a privileged class. There are also responsibilities. That the Michigan State Medical Society has accepted these responsibilities, no one can possibly deny. Yet a privileged group is always a fair target at which to shoot, and this is to be met by a campaign of education. It should be our purpose to make every effort to acquaint the public with the objectives of the organization and in particular those activities which are operated for the public weal.

It should be an obligation for state and county officers to make frequent appearances before lay audiences to discuss medical, sociological and medical economic problems, many of them to be solved only by coöperation. The publicity associated with Michigan Medical Service has had a most favorable influence in establishing a friendlier relationship between this Society and the public.

It is interesting to note that the intelligent public is

coming to recognize more and more that our postgraduate plan has its inception in the desire of this Society to improve the efficiency of its members that the highest quality of medical care may be brought to the patient.

From a public relation standpoint it will be to our advantage to utilize to the utmost the facilities of the Michigan Joint Committee on Health Education, for we have an obligation to bring factual information on health subjects to the laity, which can be well met in this way.

Our history is one of all too frequent controversies within the Society and altercations with other organizations. It is a pleasure to note that in recent years the Society has shown a great willingness to coöperate with private and state agencies. There has been an especially fine and productive coöperation with the State Board of Health and the medical schools. Difficulties will arise from time to time and I regret the unpleasantness that has arisen this year between this Society and the Executive Office of the State. In the eyes of the uninformed public this may appear to be a controversy. As we see it, it is a protest against a situation which works an injustice to the crippled and afflicted child as well as his physician.

Your Membership Committee has been studying methods through which we might capture the interest of the young physician. As of today, the senior student or the young intern, knows little of the problems which are facing the medical profession or of those which will face him as an individual when he gets into practice. He has not had brought to him the advantages of medical organization. He has, so far, led a rather cloistered life. It should be our obligation to interest these men in the work of the Medical Society. It should be our obligation to make it possible for them to become affiliated early with the Society. This might well be done by some sort of a sliding scale of fees which would be gradually increased, not coming to full payment until the end of the fifth year after graduation. There are too many young men who would like to be members of the Society who hesitate for financial reasons. But this is not enough. We should develop a definite program directed to the Senior student and the intern in an effort to interest him in organized medicine. Certainly the least that we could do would be for your president to address a letter to every graduating student, inviting him to join the County Medical Society. I would like to see an arrangement made with the medical schools whereby representatives from this Society could appear from time to time, before the senior medical students for a discussion of certain phases of medical practice and medical economics not now placed before them. An additional advantage might accrue in that it would bring the Society and the faculty of the medical schools closer together. If some of the younger members of the faculties would attend such conferences, it would be to their advantage.

Your president recommends that this House of Delegates instruct the Council to make a special effort to interest the young graduate in organized medicine; that it authorize the Council to materially reduce the dues for this group, and that it recommend to county societies that they take like action.

I emphasize my predecessor's recommendation that this House give earnest consideration to the need of the establishment of some plan whereby the destitute doctor or his family may obtain, from time to time, some help from this organization.

This, in my opinion, should be a joint effort between the County and the State Society, both organizations sharing equally in the furnishing of such assistance.

The Journal

A new editor, Dr. Roy Holmes, industrious and interested, has brought to THE JOURNAL some innovations. I think you will approve THE JOURNAL's new dress and certain changes in its makeup.

The publication of THE JOURNAL presents a very special problem. It is important that THE JOURNAL present to its readers, month by month, a report of organizational activities. In this respect it must take on some of the characteristics of a trade organ. On the other hand emphasis must be placed on the scientific side. It is the outlet for the publication of competent, scientific articles coming from our membership, and it must interest and satisfy its readers. I feel that we need to have an expression of the views of the membership as to whether THE JOURNAL fully meets their requirements.

For economic reasons, the space allotted to scientific articles has been cut about one-third from previous years. That does not meet with my approval, though others may not agree with me. I would like to see every young man encouraged to write scientific articles, with the assurance that if those articles have merit, they will be published in our JOURNAL. At the moment Doctor Holmes is compelled to refuse much desirable material.

I might note that a small foundation in Grand Rapids has taken a very unique action. They have set aside certain sums of money, I think amounting to about $500 a year, perhaps more, for $100 prizes for the best published article coming from each of the three hospitals, and then certain other prizes for very special articles which are published. They require, in order for a hospital staff to be eligible, that at least three such articles be written and published. Now it gives you an idea of what lay people think of the advantage of writing and publishing articles. A man likes to see his articles in print, and probably the only outlet that many men have is THE JOURNAL of the Michigan State Medical Society.

I would not belittle the importance of maintaining in THE JOURNAL a record of the Society's activities. That is necessary, but I feel strongly that we could improve, and should emphasize the scientific character of THE JOURNAL.

I cannot speak too highly of the efficiency of Secretary Foster and our executive secretary, "Bill" Burns. Never have I seen such persistent industry. Today the Michigan State Medical Society, with its many interests, demands for its successful operation, the same qualifications for its executives as are required for a sizable corporation. In the person of each of our secretaries, we have these qualifications and I express here, for myself and for the Society, our grateful appreciation to them for work well done.

Twenty-five years ago, at our fiftieth anniversary, President Peterson similarly gave credit to our secretary at that time, Dr. Fred Warnshuis. It seems proper and just that I should, at this time, note that during his twenty-five years of service, Doctor Warnshuis contributed largely to the foundation upon which the present structure of our Society rests.

This Society has grown strong because many men, over many years, have given generously of their time and their strength, but never more generously than they have in recent years.

You and I are grateful and are appreciative of the especially productive work of this year. With a war on our doorstep, we have special need for our strength at this time. It will be a disturbing year for men's attentions are bound to be distracted from the scientific aspects of medicine and from their medical Society. War, even the preparation for war, necessitates regimentation of doctors as well as of fighting men, and the danger of permanent regimentation under these conditions, is great. Our State Committee on Medical Preparedness is coöperating with the American Medical Association and the Federal Government. We will do our part, both as individuals and as an organization, and we will make every effort to keep our organization

strong and ready to resist, as best we can, every effort to make permanent in peace time, governmental control which we admit is a necessary concomitant in war or in the preparation for war.

I am grateful to you, officers, committeemen, delegates, for your kindly coöperation and consideration. Many are the friendships that I have made amongst you. I shall miss you as you and your successors go forward making this Society a still better and stronger organization.

And now as you proceed to your deliberations there will be important decisions for you to make in matters of policy, in finances, in the choice of personnel to whom you will delegate the affairs of this Society until you again meet.

You carry a large responsibility and a one-day session is all too short for you to adequately meet it. You are the Society. Its aims and ambitions are yours to determine. Only if it adequately meets the needs and expresses the views of its membership, will it be successful.

May you meet these problems with clear vision, untrammeled by any consideration other than your desire to make this a better society, adequately fulfilling its obligations to its members and to the public. You are fortunate in having as your next president, the experienced, competent Dr. Paul Urmston. I wish for him and the Michigan State Medical Society, a most successful year.

THE SPEAKER: Thank you, Dr. Corbus. The address of Dr. Corbus will be referred to the Committee on Officers' Reports.

We will now have the address of the President-Elect, Paul R. Urmston, M.D.

III. President-Elect's Address

American Medicine Stands Indicted

Due to vacations, baseball, European wars and our plans for preparedness the average physician is apt to forget, thereby leaving one front in our defense against socialized medicine exposed. We must awaken to the fact that we are still on the defense.

There is an old political axiom: Now is the time for all men, good and true, to come to the aid of the party. As your incoming President I am now making an official call for all Doctors of Medicine, good and true, to rally in the defense of American Medicine.

Shall the practice of Medicine become a trade or a science?

Woe unto the ethics of Medicine, if it becomes a trade!

After due deliberations of the House of Delegates at two sessions, the trustees of the A.M.A. advocate the following Platform:

1. The establishment of an agency of the federal government under which shall be coördinated and administered all medical and health functions of the federal government exclusive of those of the Army and Navy.
2. The allotment of such funds as the Congress may make available to any state in actual need, for the prevention of disease, the promotion of health and the care of the sick on proof of such need.
3. The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.
4. The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.
5. The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.
6. In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.
7. The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.
8. Expansion of public health and medical services consistent with the American system of democracy.

These are the principles or the banner under which we will carry on our defense for the rights of American Medicine under our American Democracy. These should be adopted as the Michigan platform in the aid given to the A.M.A. in the defense of our citizenship rights. Our offense is the ballot.

Do you read the organization Section of the *A.M.A. Journal?*

Do you know about all the bills sent to Congress? Read this and your Michigan State JOURNAL to keep up with the trend of the times.

It seems that politicians are of the same opinion regardless of party, that Medicine must be trampled upon and be subservient to their wishes.

If we cannot convince the people of Michigan who are our patients that Medicine is a science (and every other State in the union does the same) we cannot influence our national representatives and the Supreme Court Justices that the regimentation of Medicine eventually but surely spells the fall of democracy.

Now for some medical problems in the State of Michigan.

Child Welfare

The annual convention of the American Legion was held in Bay City in August. Two days were devoted to the subject, Child Welfare. This headed all other activities. All interested organizations on this subject were invited to attend; federal appointees, social agencies, Judges of Probate, and others were present. The medical profession was well represented by the Child Welfare Committee of the Michigan State Medical Society, some of your officers, and many interested in the American Legion.

Dr. Whitaker of Detroit ably presented the aim of the Legion in caring for the children of Michigan which included both the Crippled and Afflicted Acts.

Dr. L. F. Foster presented the difficulties physicians have had trying to care for the children under the crippled and afflicted child laws of Michigan.

Trying to balance the budget (in the black) by our present administration has caused untold suffering and future expense.

To criticize and not produce something constructive we would fail to aid the Legion in solving this problem.

The following recommendations were presented to the Legion:

1. Increase the appropriations to a reasonable sum so that needed care is given to crippled and afflicted children, and cost fees are paid to physicians and hospitals.
2. Control intake and limit State care to the indigent and medically indigent by authorizing by law a thorough economic and medical investigation of every applicant.
3. All groups sincerely interested in unfortunate crippled and afflicted children should meet to devise a sound and permanent plan so that Michigan's crippled and afflicted child program will become the best rehabilitation program in the country.

Several organizations have started to revise these two acts and the Michigan State Medical Society has appointed or has asked physicians to serve with these agencies. The salvation of the unfortunate children

and their only hope is that through these groups will be evolved an Act that will meet the test of time. The Michigan State Medical Society hopes to aid and direct in this Ideal Act which will be fair to the children and the tax payers of Michigan.

I am not forgetting the much abused physicians who are caring for the afflicted without recompense.

Medical problems can only be solved by coördination of ideas between administration and the Michigan State Medical Society.

Welfare Laws

My last statement was made because our welfare laws have not accomplished all that is desired. This is because one paragraph is too well written, that is, *the free choice of physician.*

This part of the law is being evaded in several counties by their employing full-time county doctors or contracting with individual doctors. The law also provides the use of the city physician. This phase of the law is wrong, and ably demonstrates what will happen if we have socialized medicine.

In one of our large cities of this State we hope the investigation will show that the regimented physician cannot practice good medicine.

The people of Michigan should follow the trend of this investigation as this is what will happen to them under similar conditions. We are fortunate that the act provides a Doctor of Medicine on the State Board. This Board has interpreted the act fair and wisely. The inactivity of the county medical societies where this law is evaded jeopardizes the good results in other counties.

School Inspection

School inspection is another part of Child Welfare that is receiving National Study and is receiving definite attention in Michigan. The administration has appointed committees with medical representation to conduct this survey.

The problems that affect the medical societies are:

1. Pre-school examinations
2. Examination of interscholastic athletes
3. Examination of vision
4. Examination of hearing
5. Care of school injuries
6. Tests for tuberculosis
7. Prevention of communicable diseases

This raises the question who shall conduct these examinations:

1. A full-time salaried medical attendant
2. Part-time physician
3. Instruct the teachers how to screen children for apparent defects or diseases and, when found, refer them to the family physician

This latter maintains the patient-doctor relationship which is to be desired. No other physician is examining your patients. This is entirely a medical activity and must be solved by the medical profession.

School superintendents or school boards should not have the right to appoint other physicians to examine your patients but should coöperate with the county society in all medical matters.

Medical preparedness of the child up to twenty-one years for war. Congress has passed a bill for registration of the youth of America for military duty. How will the youth of today compare with the youth of the last war? Of the reecnt volunteer applicants 32 per cent were rejected. Are we to be held responsible for the physical and mental defects of the youth of today? If so we must care for the child from birth:

1. We must prevent blindness by ophthalmic neonatorum or by inherited syphilis.
2. We must preserve his hearing.
3. He is made immune by known method for communicable diseases.
4. By pre-school examinations we find his defects and are corrected before he enters school.
5. His diet should be regulated.
6. During his school period he has a physical examination every three years.

When he is twenty-one years old, if he continues in school, he is as near perfect as we can expect at the present period. How is this to be achieved? By registering the child at birth for military training. A complete family history accompanies his classification card through each grade. His habits, initiative, desires, adaptability, conduct and progress are entered on his card.

If at the end of his grade schooling he shows no desire or his progress is slow he should be sent to a vocational school. The recent call for trained tool and die makers and mechanics showed a shortage of trained men.

These vocational schools should give a complete training for services in factories or any mechanism required in war.

This is a much neglected part of our present system. This, as a part of his education, should be credited on his diploma.

His conduct outside of school hours must be regulated. If we are to become a military country, we must give this serious thought.

The Medical Corps

The House of Delegates of the American Medical Association passed a resolution and appointed a committee to coöperate with the Federal government to register all Doctors of Medicine in America.

A Medical Preparedness Committee is appointed in this State. You will hear much on this subject during this convention. My only thought on this subject is that we may eliminate many of the errors of the Medical Corps of the last war. The status of the Medical Corps should be raised.

All this would indicate that we have not accomplished much this year. Your council report shows the extraordinary progress of the year. These were last-minute problems.

Medical science cannot stand still. The United States of America is the only country left where it can still progress unhampered as a free institution. We shall maintain a free country. We shall also maintain our rights and freedom under the Constitution of the United States and the right to practice Medicine in the American way.

I am not a philosopher but I like this definition, "One who reduces the principles of philosophy to practice in the conduct of life." One who meets or regards all vicissitudes with calmness.

I am neither orator, writer nor a poet. I seek wisdom from those whose aim in life is for the interest of all. This wisdom I shall impart to you when it is for the good of Medicine and the rights of our patients. I have learned to obey and also to give orders but for those whom I have asked to serve, it is not a command but a duty to our fellow members.

If I were chosen on my past record to this honor, it was only with your help, for which I give due credit, and with the unity of all members we can solve the problem of the future.

We face a national election that may govern our future but we must meet this with the philosophy of the Stoic, that is, the wise man should be free from passions, unsubdued by joy or grief, willingly submissive to natural law.

Doctor, you should psychoanalyze yourself; also, read the code of ethics. Lastly, in the saying of a Greek Philosopher, "Know thyself."

THE SPEAKER: Thank you, Dr. Urmston. The address of Dr. Urmston will be referred to the Committee on Officers' Reports.

X. NEW BUSINESS

X-1. SCROLL PRESENTED TO PHILIP A. RILEY, M.D.

It is now my pleasure to call on Frank E. Reeder, M.D., of Flint.

FRANK E. REEDER, M.D.: Dr. Philip Riley, if you will rise, it is my privilege and my pleasure, in recognition of your long and faithful service as member and as speaker of this House of Delegates, to present you with this beautiful scroll, which I read:

To Philip A. Riley, M.D., Speaker of the House of Delegates, 1938-39, in recognition of his valuable services to the Michigan State Medical Society.
September 24, 1940

BURTON R. CORBUS, M.D.
President
L. FERNALD FOSTER, M.D.
Secretary

Dr. Reeder presented the scroll to Dr. Riley.

PHILIP A. RILEY, M.D.: Mr. Speaker, Dr. Reeder: Last Sunday morning, I heard Major Bowes make an inquiry of an orchestra leader. He said, "When you left Harvard, did you leave by invitation or by diploma?" Now, I have left by diploma. (*Laughter*)

I am not worthy of receiving any special honor from the Michigan State Medical Society. I had a good time doing any work that I did. When I came to this House of Delegates, I was just as green as the fields are out our way, and I have learned a lot. Probably the biggest thing I have learned in the House of Delegates is that all good fellows in the practice of medicine did not live in Jackson County. I thought they did. I have also learned how to evaluate the various emotions of different men. I have learned to distinguish between passion and zeal.

I want to thank the Michigan State Medical Society for this honor. (*Applause*)

THE SPEAKER: Henry R. Carstens, M.D., Chairman, will present the Annual and Supplementary Reports of the council.

IV. Annual Reports of the Council

HARRY R. CARSTENS, M.D.: Mr. Speaker and Members of the House of Delegates: The Annual Report of The Council for the year 1939-40 appears in the Delegates' Handbook beginning at page 29. As this report was writen in July so that it might appear in print, we wish to submit additional information on matters which have been considered by The Council and its Executive Committee during the past few months.

Membership.—The membership of the Michigan State Medical Society is at an all time peak of 4,436. It would appear that the prophesy that the State Society would end the year 1940 with 4,500 members will easily be fulfilled.

Meetings of allied medical groups coincident with the Annual Meeting of the Michigan State Medical Society: Our recommendation to the House of Delegates at the 1939 session to encourage other medical groups to meet at the same time and place as the Michigan State Medical Society, has borne fruit. The Michigan Association of Industrial Physicians & Surgeons is meeting this year in Detroit, today, and this evening. This closer association will result in better coördination of medical work and service in all its branches, particularly important in Industrial Medicine at this moment of military preparedness.

Fund to aid impoverished physician-members and the widows and orphans of deceased members of the Society: This study, referred to The Council by the 1939 House of Delegates, is mentioned on page 37 of the Handbook. The suggestion to create a fund from contributions by Michigan physicians was made the subject of a questionnaire and sent to all county society secretaries by The Council. Following is the analysis of replies:

Twenty-six societies, representing thirty-three counties, replied to the questionnaire, as follows:

Q. 1. In your county, do you know of any specific cases of want by a member or former member, or neglect of a doctor's family by reason of his death? (By want and neglect might be interpreted lack of advantages for children to complete their education, et cetera.)

A. Twenty-six replies were received, of which seventeen replied "No," and nine replied "Yes," eight of whom qualified this answer by saying "Only one in recent years," and one county had only two cases.

Q. 2. In your estimation, what percentage of doctors leave sufficient money to provide for their families at their death?

A. Two said "All"; 7, "Most"; "90 to 99 per cent": 5; "80 to 90 per cent": 2; "70 to 80 per cent"; one; "50 to 60 per cent": two; "above 40 per cent": one; "30 to 40 per cent": one; five did not give any estimate.

Q. 3. As County Society Secretary, what is your personal opinion of this proposed plan and what are your suggestions?

A. *Eleven* thought it a good idea; *seven* were opposed to the plan and suggested that a program of educating the doctor to provide for his dependents through an adequate personal insurance program would be more effective; *three* believed such a plan was not necessary; *four* thought this problem should be handled locally; *one* suggested dues of State Society be increased to set up such a fund; *two* suggested more study; *one* suggested Michigan State Medical Society set up a loan fund; *two* believed it would be impossible to make it compulsory and therefore difficult to collect funds and the plan would be unworkable; *one* suggested that these cases be referred to welfare agencies already existing; *one* stated that it was "absolutely unnecessary and un-American."

Roughly, eleven county society secretaries favored the idea while fifteen definitely opposed it or offered substitutes. It is to be noted that no replies were received from 28 county society secretaries whose territories comprise 50 of the State's 83 counties. This might suggest that there is little interest in, or small need for, the creation of a fund for impoverished physicians, their widows and orphans in Michigan.

Preparedness.—Today you have heard much about Medical Preparedness in the excellent reports of the Officers. Associated with this important matter is the question of a moratorium or remission on the medical society dues of members who enter military service. A recommendation on this subject follows:

Michigan Medical Service.—An up-to-date report shows a total of over 67,000 subscribers, for whom approximately 3,000 services have been performed, with $120,000 being paid to the physicians who rendered this medical care. Thirty-three hundred doctors of medicine have signified their willingness to cooperate with the Corporation in bringing service to the lower income groups. The Balance Sheet, and other financial reports, which will be presented to the

members of Michigan Medical Service on Wednesday, are both satisfactory and encouraging.

Medical Relief.—The administration of medical relief to those on Welfare is in a very chaotic condition in Michigan at the present time. The State Society and its Legislative Commitee labored unceasingly in the Legislature of 1939 to establish the cardinal principle of the physician-patient relationship. The recent Michigan State Medical Society survey on Medical Welfare in Michigan (published in the August JOURNAL) brings out the fact that the law is being evaded in this respect in a number of counties. Moreover, criticism from the politicians of some counties is jeopardizing the satisfactory and law-abiding contracts which some nine or ten county medical societies have with their County Social Welfare Boards. In recent weeks, the Social Welfare Commission, after a great deal of pressure has matched the salaries of physicians who are working full time supplying medical relief to welfare patients in clinics and dispensaries. In other words, full-time county physicians, appointed by politicians, are gradually eliminating the family physician-patient relationship or free choice of doctor for which the State Society battled six months last year. This objectionable condition will increase and multiply—unless the county medical societies stand up for the letter and spirit of Act No. 280—the Welfare Law of 1939. This is a serious situation which can be rectified only by *instant action* by the medical profession in those counties where the law is being evaded. This is a matter of "*doing* now—or forever holding your peace." A recommendation on this subject follows.

Crippled-Afflicted Child Laws Administration.—The 1939 Legislature appropriated only $300,000 for crippled and $500,000 per annum for afflicted child care (about one-third the former appropriations). This was a severe measure to help balance the budget. In the words of Governor Dickinson, the appropriations were too drastically cut. However, nothing was done to remedy the bad situation—except to slash doctors' fees 40 per cent below the *actual cost* of doing business (the doctors already giving the State 50 per cent discount or *cost price* on care of crippled and afflicted children). No other commodity is purchased by the State at 50 per cent discount!

Did the medical profession strike, as would have been done by some other groups? NO. The physicians in 61 of the 83 counties refused the far-less-than-cost fees arbitrarily imposed, without consultation with them; they decided to perform the needed medical work on Michigan's victims of infantile paralysis and other diseases as their own private CHARITY—until such time as the *Legislature could see that justice was done.*

Despite the altruistic work of our doctors of medicine, the Michigan Crippled Children Commission reports that 937 crippled children (and no one knows how many afflicted children!) who should have had immediate treatment last year (up to June 30, 1940) have received no care. Their future care will cost the State far more than a continuing rehabilitation program now. A recommendation on this subject follows.

Renewal of Corporate Term of Michigan State Medical Society.—As stated on page 37 of the Handbook, the Michigan State Medical Society received a charter from the State of Michigan thirty years ago. This summer, when The Council attempted to renew the term of that charter for another thirty years, we were advised the law required that *all* members of the Michigan State Medical Society be called together to vote on the proposition! This you will readily see is impossible of performance, especially when the membership of our Society represents a large plurality of all the medical practitioners in the State; someone must stay at home to care for the sick! However, the law is the law, and the best arrangement that could be made with the Michigan Corporation and Securities Commission is the following: that at a general meeting, the membership of every county medical society should vote in favor of the extension of the Michigan State Medical Society's charter and empower its delegate or delegates to the 1941 Michigan State Medical Society House of Delegates to represent the members in the vote on the charter renewal. Therefore, in order to continue the life of the Michigan State Medical Society, this legal red-tape must be followed. Meanwhile, we have a two-year grace period. A recommendation on this subject follows.

Authorization to Levy Assessment.—You will recall that at the 1938 and 1939 session, the House of Delegates authorized The Council to levy an assessment of $5.00 on every member of the Michigan State Medical Society, as seemed justified in the opinion of The Council. The Council is gratified at your confidence and is very happy to state that matters were so well arranged by its Finance Committee that no direct assessments were required. A recommendation on this subject follows.

The Council is appreciative of the splendid cooperation it has had from members of the Society during the past year—one of the most active and important periods in the association's history.

I wish to thank all members of The Council and especially the Executive Committee—particularly those who served in a dual capacity as members of the Board of Directors and Executive Committee of Michigan Medical Service—for their devotion to the many tasks assigned during the past twelve months. Without their loyalty and fine spirit of coöperation, and indeed their costly sacrifice of hours and days of time attending thirty-six long sessions, transacting the important business of Medicine, we could not have made the rapid progress which is reflected in the reports of the State Society and of Michigan Medical Service.

Recommendations

The Council's first four recommendations are published in the Handbook, on page 38. I shall read them, to re-invite them to your attention:

1. That all county medical societies retain efficient Secretaries and Delegates, who are the sparkplugs of the county and state organizations.

2. That a Doctor of Medicine always be retained as a member of the State Social Welfare Commission which needs the help of such a qualified professional man to aid it with the many technical questions concerning the fifth necessity, medical care.

3. That approval be given to contact work with insurance associations, to the end that voluntary agreements providing for liens in accident cases for physicians' services may be developed in Michigan.

4. That a public relations department be maintained in the executive office of the Michigan State Medical Society, to bring to officials of governments and to the people the facts concerning medical problems and progress, and that the Council be instructed to set aside an annual appropriation for the proper maintenance of this important bureau.

The Council offers these additional recommendations, covering matters presented in this Supplemental Report:

5. That a moratorium or remission on Michigan State Medical Society dues of members in military service be authorized, to be effective for the period the individual physician is on active full-time duty in the U. S. Army, Navy, Marine, or National Guard; and that our County Medical Societies study the feas-

ibility of a like moratorium or remission for county society dues.

6. That every county medical society take aggressive action to the end that county Welfare Boards comply with the provisions of the Michigan Welfare Law, especially with relation to the cardinal principle of the physician-patient relationship; and that Delegates, who come from those counties or districts where the law is not being complied with, be instructed to appear this autumn before their county medical societies and present full information on this serious infringement of patients' rights, in order that early action may result in all parts of the State. Further, that county societies contact their Boards of Supervisors before October 1, on which date their annual budgets will be adopted. Finally, that all members of the Michigan State Medical Society be urged to inform their welfare patients of their legal rights, so far as medical service is concerned.

7. That all groups sincerely interested in unfortunate crippled and afflicted children should meet to devise a sound and permanent plan so that Michigan's crippled and afflicted child program will become the best rehabilitation program in the country; that the appropriations should be increased to a reasonable sum so that needed care is given to crippled and afflicted children, and cost fees are paid to physicians and hospitals; that the intake should be controlled and State care limited to the indigent and medically indigent by enacting a law authorizing a thorough economic and medical investigation of every applicant for aid under the Crippled Child Act and the Afflicted Child Act.

8. That the House of Delegates urge county medical societies and individual physicians to maintain contacts with U. S. Congressmen, Michigan legislators, and all other office holders whose duties pertain to legislation and administration of matters affecting the health of our citizens and the practice of medicine.

9. That every county medical society, at a general meeting this autumn, present to its membership a resolution calling for the extension of the Michigan State Medical Society's charter, and empowering its delegates to represent the members on this question when it is presented to the 1941 House of Delegates.

10. That the House of Delegates re-affirm its authorization to The Council to levy a capital assessment, or assessments, not to exceed a total of $5.00, as seems justified in their considered opinion.

In conclusion, I wish to state that The Council has been trying not only to protect but to promote the interests of all of our members, realizing that the status of Health and Medicine in Michigan will improve in direct proportion to the satisfactory position of those who serve the public in medical matters.

THE SPEAKER: Thank you, Dr. Carstens. The Reports of the Council will be referred to the Committee on Reports of The Council.

The next order of business is the Report of the Delegates to the American Medical Association by Henry A. Luce, M.D.

V. Report of Delegates to A.M.A.

HENRY A. LUCE, M.D.: Mr. Speaker, that report is published in the Handbook, to which your attention is invited.

THE SPEAKER: The report of the Delegates to the A.M.A. will be referred to the Committee on Officers' Reports.

THE SPEAKER: The next order of business is the presentation of resolutions.

VI. Resolutions

VI-1. GENITO-INFECTIOUS DISEASE PROGRAM

C. K. VALADE, M.D. (Detroit): Mr. Speaker, I have a resolution on the Venereal Disease Program, hereafter spoken of as the Genito-Infectious Disease Program.

Dr. Valade read a resolution on the Genito-Infectious Disease Program.

THE SPEAKER: This Resolution will be referred to the Reference Committee on Reports of Standing Commitees.

VI-2 NEW GAVEL TO SPEAKER

T. K. GRUBER, M.D. (Wayne County): I have been instructed and requested by The Council of Wayne County Medical Society and the delegates representing the Wayne County Medical Society, to present the following resolution.

Dr. Gruber read the resolution on the presentation of a new gavel to the speaker.

THE SPEAKER: This reslution will be referred to the Committee on Resolutions.

VI-3. SPECIAL MEMBERSHIPS (EMERITUS AND RETIRED)

Henry E. Perry, M.D., of Luce County read a resolution asking for the election of Frank P. Bohn, M.D., of Newberry to Emeritus Membership.

THE SPEAKER: This resolution will be referred to the Committee on Resolutions.

VI-4. CHANGE OF COUNTY SOCIETY NAME

C. R. KEYPORT, M.D. (O.M.C.O.R.O.): Mr. Speaker and Members of the House of Delegates: I have been instructed by my County Medical Society to present the following resolution. This resolution deals with the annexation of two counties to our six counties in North Central Michigan and also deals with the change of the name of the Society. The members of these two adjacent societies are now members of our county society.

Dr. Keyport read the resolution on changing the name of the O.M.C.O.R.O. County Medical Society and including Kalkaska and Gladwin Counties.

THE SPEAKER: The resolution offered by Dr. Keyport will be referred to the Committee on Resolutions.

VI-3. SPECIAL MEMBERSHIPS

J. A. Wessinger, M.D., of Washtenaw County read a resolution requesting that James B. Wallace, M.D., of Saline, Michigan, be granted retired membership.

THE SPEAKER: This resolution will be referred to the Committee on Resolutions.

FRANK E. REEDER, M.D.: I am instructed by the membership of the Genesee County Medical Society to present for Retired Membership the name of Mark S. Knapp, M.D. Dr. Knapp is well known, I am satisfied, to almost everybody in this House. He has been an active member in the interest of organized medicine for thirty-four years. Because of physical reasons he is unable to continue practice.

THE SPEAKER: The resolution offered by Dr. Reeder will be referred to the Committee on Resolutions.

VI-5. AMENDMENT TO AFFLICTED CHILDREN'S ACT

A. L. CALLERY, M.D., (St. Clair County): I have been asked by some members to submit the following resolution.

Dr. Callery read a resolution asking for the amendment of the Afflicted Children's Act.

THE SPEAKER: This resolution will be referred to the Reference Committee on Standing Committees.

VI-3. SPECIAL MEMBERSHIPS

G. C. PENBERTHY, M.D. (Wayne County): Mr. Speaker and Members of the House of Delegates: I have been instructed by the Wayne County Medical Society to make the following recommendation for Emeritus Membership.

Dr. Penberthy read the resolution recommending for Emeritus Membership, James H. Sanderson, M.D.; and a resolution recommending for Associate Membership, Mr. John Mannix.

THE SPEAKER: The resolution offered by Dr. Penberthy will be referred to the Committee on Resolutions.

VI-6. PUBLIC RELATIONS

C. F. DEVRIES, (Ingham County): In keeping with Recommendation No. 4, made by The Council, I wish to present the following resolution.

Dr. DeVries read the "Resolution re Public Relations."

THE SPEAKER: The resolution offered by Dr. DeVries will be referred to the Reference Committee on Reports of the Council.

VI-3. SPECIAL MEMBERSHIPS

M. G. BECKER, M.D., of Gratiot-Isabella-Claire Counties read the resolution recommending for Emeritus Membership, Leslie A. Howe, M.D., of Breckenridge.

THE SPEAKER: The resolution offered by Dr. Becker will be referred to the Reference Committee on Resolutions.

VI-7. MATERNAL HEALTH

C. T. EKELUND, M.D., (Oakland County): I have been asked to present a resolution which is admittedly on a controversial subject, and I only bespeak for it your careful understanding. This is on the question of contraception and is promulgated by the Maternal Health League of Michigan.

In presenting this resolution, it should be borne in mind that their program has been in continuous operation since 1927, and that the Section on Gynecology and Obstetrics of this Society held a symposium on contraception in 1933 and gave its approval to the work of that organization at that time. Since then the State and County Health Departments have been unofficially aiding that program in one way or another, and this resolution aims to make that aid official.

Dr. Ekelund read the resolution on Birth Control.

THE SPEAKER: The resolution offered by Dr. Ekelund will be referred to the Reference Committee on Resolutions.

VI-3. SPECIAL MEMBERSHIPS

T. E. HOFFMAN, M.D., of Tuscola County read a resolution recommending for Emeritus Membership, George Bates, M.D., of Kingston.

THE SPEAKER: The resolution offered by Dr. Hoffman will be referred to the Resolutions Committee.

George A. Sherman, M.D., of Oakland County read the resolution recommending for Retired Membership, C. J. Sutherland, M.D., of Clarkston.

THE SPEAKER: The resolution offered by Dr. Sherman will be referred to the Reference Committee on Resolutions.

VI-8. BEAUMONT BRIDGE

Henry A. Luce, M.D., of Wayne read a resolution on Naming the Bridge connecting Mackinaw City with St. Ignace.

THE SPEAKER: The resolution offered by Dr. Luce will be referred to the Reference Committee on Resolutions.

VI-3. SPECIAL MEMBERSHIPS

Paul Engle, M.D., of Eaton County read a resolution recommending for Retired Membership, C. S. Sackett, M.D., of Charlotte.

THE SPEAKER: The resolution offered by Dr. Engle will be referred to the Reference Committee on Resolutions.

J. H. Kirton, M.D., of Houghton-Baraga-Keweenaw read a resolution recommending for Emeritus Membership, Donald K. MacQueen, M.D., of Larium.

THE SPEAKER: The resolution offered by Dr. Kirton will be referred to the Reference Committee on Resolutions.

D. C. Denman, M.D., of Monroe County read a resolution recommending for Retired Membership, E. M. Cooper, M.D., of Rockwood.

THE SPEAKER: The resolution offered by Dr. Denman will be referred to the Reference Committee on Resolutions.

VII. Amendments to Constitution

VII-1. PROPOSED AMENDMENT TO CONSTITUTION

PAUL W. KNISKERN, M.D., (Kent County): This is a proposed amendment to the Constitution, of the Michigan State Medical Society. It has two purposes: first, to elucidate the language of the Constitution in so far as it empowers us to invest our funds in bonds and stocks; second, to limit such investments to Government bonds.

Dr. Kniskern read the proposed amendment to Article IX, Section 4.

THE SPEAKER: The resolution offered by Dr. Kniskern will be referred to the Commitee on Amendments to the Constitution and By-Laws.

VI-9. GENERAL PRACTITIONERS IN HOSPITALS

G. L. MCCLELLAN, (Wayne): Mr. Speaker, I have been requested by some general practitioners of Detroit to have this introduced from the floor of the House.

Dr. McClellan read a resolution with reference to extending more liberal consideration to the General Practitioners in Class A Hospitals.

THE SPEAKER: The resolution offered by Dr. McClellan will be referred to the Committee on Resolutions.

I shall declare a recess of ten minutes.

Ten-minute recess.

THE SPEAKER: I wish to announce that when we convene this afternoon, we will go into executive session. So often matters arise that some delegate wishes the House to go into executive session. To avoid any embarrassment to members of the press and others, we will declare the first part of the afternoon session to be an executive session, and any matters of that kind can be brought up then.

VI-3. SPECIAL MEMBERSHIPS

DEAN W. MYERS, M.D. (Washtenaw): Mr. Speaker, it has come to the attention of the delegates from Washtenaw County that we have a member in our county who should be placed upon the list of Retired Members, James F. Breakey, M.D., who is retired from practice and is now entitled to Retired Membership. He has practiced medicine for over forty-four years, and about twenty-five years ago was President of the Washtenaw County Medical Society. We recommend that he be transferred to Retired Membership.

THE SPEAKER: The resolution offered by Dr. Myers will be referred to the Committee on Resolutions.

GEORGE SOUTHWICK, M.D. (Kent): I have been asked by Kent County Medical Society to present the names of two of our members of the County Society for Retired Membership.

I would like to present the names of W. E. Wilson, M.D., and T. W. Hammond, M.D., for Retired Membership.

THE SPEAKER: The resolution offered by Dr. Southwick will be referred to the Reference Committee on Resolutions. There might be some delay on these last offered, because they have not been checked by the office at Lansing, and a telephone call will have to be made to verify their period of membership.

We will now go to the next order of business, the Reports of Standing Committees.

Owing to the fact that Dr. Campbell has another engagement, I will call on him first for the Report of the Maternal Health Committee.

VIII. Reports of Standing Committees

VIII-1. MATERNAL HEALTH

A. M. CAMPBELL, M.D., (Grand Rapids): Mr. Speaker and Gentlemen: This is a supplementary report which was not presented in time to appear in the Handbook. It concerns a survey which the Committee on Maternal Health made last year of the facilities for the care of maternity cases in the licensed maternity hospitals and maternity homes.

We realize, as a committee, that practically fifty per cent of the babies are born in hospitals in this state, and we are concerned as to what type of care some of these women receive, especially in the smaller hospitals and in the maternity homes. Consequently, we got up a survey and presented it to the Social Welfare Department, and through the supervision of Miss Robinson the survey was carried out. Miss Robinson personally saw that all these survey blanks were pretty carefully filled out. The result is that there are 611 hospitals in the state that render maternity service and 68 maternity homes.

Now, some literature has appeared recently which indicates that possibly the small hospital presents an obstetric hazard. A recent article brings out the suggestion that any licensed hospital that cannot take care of 150 births a year probably is not sufficiently equipped to safeguard the mother adequately.

With that in view, we got a few statistics together. I will not bore you with any great detail, excepting that the survey shows we have in Michigan 129 maternity hospitals in which there are less than 150 births annually, and the statistics show that the maternal mortality from that group is a trifle higher than the maternal mortality for the larger hospitals, but it is not very appreciably higher. We were surprised, in fact, to note from this survey that the maternal mortality in the small hospitals was as low as it is. The maternal mortality in these small hospitals is almost comparable with the maternal mortality the state over, which in 1938 was 3.56 per thousand births. There are 2,704 bassinets in the State of Michigan. These hospitals took care of 52,661 patients, and the state's complete birthrate in 1938 was 96,902. In other words, the hospitals in the State of Michigan are taking care of over 54 per cent of the births in the state.

Now this problem, "Is the small hospital a menace?" is an important one, and all we can say at the present time is that our statistics do not indicate that the small hospital is such an obstetric hazard as some men who have written about it believe it to be.

We do, however, believe that the three qualifications should be more carefully lived up to than they are; and those are the qualifications demanded by the American Hospital Association and the American College of Surgeons, that an obstetric department must be separated entirely from the other parts of the hospital; that the attendants at these cases, particularly the nurses, must not do any other type of work in any other part of the hospital; and that the hospital is responsible for the supervision and the care that these expectant mothers receive.

This study also brings out the fact that there are about sixty incubators in the entire state, some of them very old and very inefficient. In that connection, you might be interested to know that in the State Department of Health, the Chief Engineer has been working for two years in an endeavor to have them make an incubator that is cheap and portable, and that has not been completed as yet.

This study brings out, in brief, that the maternal mortality in smaller hospitals is slightly larger than that in the state at large.

Now, a word about maternity homes. We are concerned about those, because they are really only substitutes for the homes in which the economic and social conditions make it impossible to have a woman taken care of properly. This study concerns only about one per cent of the babies that are born, but it shows that the maternal mortality was lower than in any other group. Thank you very much.

THE SPEAKER: The Report of the Maternal Health Committee will be referred to the Reference Committee on Reports of Standing Committees.

We will now have the Report of the Legislative Commitee. Dr. Miller.

VIII-2. LEGISLATIVE COMMITTEE

HAROLD A. MILLER, M.D.: Mr. Speaker, Members of the House of Delegates: You will find the Report of the Legislative Committeee on page 45 of the Handbook. This year the committee has been comparatively inactive, except in an advisory capacity. For the coming year the Committee plans no aggressive projects.

We know that the cultists are going to be very active this coming year. Talks have been given by Dr. Urmston and Dr. Carstens with their recommendations for the future, in regard to your activity in the welfare setup in your county, and the state legislation has been dwelt on. I want to recommend that you do find out what the legislators in your community plan to do in regard to your welfare problem.

The second thing is in regard to the afflicted and the crippled child. The recommendations have already been given, and they have been approved by our Legislative Committee.

It is going to be necessary, as in the years past, for not only the delegates to be interested in this problem of legislation, but every member of the State Society should be a cog in helping us in the Legislative Committee to do your work at Lansing.

THE SPEAKER: Thank you. The report will be referred to the Reference Committee on Standing Commitee reports.

Next we will have the report of the Representatives to the Joint Committee on Health Education. Dr. Jackson.

VIII-3. REPRESENTATIVES TO JOINT COMMITTEE ON HEALTH EDUCATION

BURTON R. CORBUS, M.D.: Mr. Speaker, Dr. Jackson has asked me to state that there is no supplementary report.

THE SPEAKER: The report of the Representatives to the Joint Committee on Health Education will be referred to the Reference Committee on Standing Committees reports.

VIII-4. COMMITTEE ON DISTRIBUTION OF MEDICAL CARE

S. W. HARTWELL, M.D.: Mr. Speaker and Members of the House of Delegates: The official report of the Committee is published in the Handbook for Dele-

gates, on page 51. I have a few supplemental remarks which I want to make, together with a demonstration of the maps which have been derived from the information which was sent to us by the secretaries of the component societies.

It has been the custom in the past few years for anyone who thinks socially, and most people pride themselves on doing that, to speak liberally of the distribution of medical care, whether or not he knows anything about it. It appeared to us that one of the necessary things for us was to place facts on paper in such a way that we could analyze what it is we are talking about, and for that reason we have started the development of maps, which are aimed to show the distribution of all phases of medical care in Michigan.

As a result of questionnaires sent to the component societies, requesting information concerning the location of practicing physicians of all types, of laboratory procedures, and of hospital beds of all types, we have started these maps which I wish to demonstrate here.

In the consideration, however, of the distribution of medical care, there are several factors which are not purely medical and which are usually left out of social thinking. One of those questions is: How many people are in the neighborhood? The other question is: If the people are there, how much money is there to take care of them, whether that money be governmental money or individually owned money?

So these two factors, the purchasing power of the locality, the number of persons in the community, bear a direct relation to the distribution of medical care and to where additional medical care should be added, and possibly to some places where it might well be subtracted.

For that reason, we set out to show the distribution of the population of Michigan, not by counties but by townships, and using one hundred persons for every dot, we have made a stippled map of Michigan, showing the population as it is actually spread across the state. This is shown on this map. Naturally, the actual population of cities cannot be so demonstrated, and symbols have had to be used for that demonstration.

Going hand in hand with the distribution of population is its purchasing power. There are many ways of displaying this. However, it seemed that as our services are almost entirely comparable to the services which are bought by people who purchase retail goods, the distribution of retail sales would be a satisfactory index to use. Therefore, we have plotted the counties according to their retail sales percentage for the State of Michigan.

In this map, the red represents 83.41 per cent of the purchasing power of the state; the yellow represents 9.2 per cent; the green, 5.1 per cent; and the blue, 2.3 per cent. We hope that when the figures of the 1940 census are available, we can combine the two types of maps that are on that board, with the distribution of the 1940 population combined on the same map, with the shading showing the purchasing power as represented also in 1940. These maps have been developed from the 1930 census.

With that combined map as a base map, we have in mind establishing a visual representation, which would be subject to showing any phase of medical distributive factors—laboratory, specialists, general practitioners, hospital beds, and so forth. To demonstrate that, I have brought a map showing the distribution of practicing Doctors of Medicine in the State of Michigan. These are shown by pins and again we had the problem of representing actual numbers, and had to diminish the spread of numbers by using different-colored headed pins for varying numbers of physicians in any one locality. The shaded area represents the counties from which we have no report available.

It is our belief that, aided with such visual and analyzable statistics, it may well be possible to plug up certain holes which undoubtedly exist in the adequate distribution of medical care in Michigan, and in so doing possibly to make it a little bit more difficult for the people of certain communities to look upon cultists as the only physicians in their communities.

THE SPEAKER: Dr. Hartwell's report will be referred to the Reference Committee on Reports of Standing Committees.

The next is the Medical-Legal Committee.

S. W. Donaldson, M.D., represented the report, as it appears in the Handbook.

VIII-5. MEDICAL-LEGAL COMMITTEE

THE SPEAKER: The Report of the Medical-Legal Committee will be referred to the Reference Committee on Reports of Standing Committees.

We will now have the Report of the Postgraduate Medical Education Committee.

VIII-6. POSTGRADUATE MEDICAL EDUCATION COMMITTEE

J. D. BRUCE, M.D. (Ann Arbor): Mr. Speaker, I have no written supplementary report, but I would like to make a little oral report to you; that is, to congratulate the Society upon their persistency in following through with a program of postgraduate education.

I read last night a part of the Report of the Commission on Medical Education, just issued, and in that report it is stated that in twelve states of the Union doing most in postgraduate education the average attendance in the postgraduate programs is twenty-five per cent of the state membership. I think we should congratulate ourselves on the fact that we have slightly in excess of fifty per cent of the state membership, unless the state membership has been boosted within the last few weeks.

In addition to that, the Commission on Medical Education reënforces us in the kind of program we are presenting. You probably recall that the programs differ in different states, but in the Michigan program there are more of the features that are commended by the Commission than in any of the states that have been examined by its representatives.

This year I am glad to announce a further step in our work in the recognition of qualified men. Up to the present, we have been giving certificates, as you all know, for attendance of sixty per cent or more over a four-year period, which qualify a man for an associate fellowship in postgraduate education. At the end of a second period, he is entitled to a certificate of fellowship.

In discussion with Dean Norris of the Wayne University Medical School, and Dean Furstenberg of the University of Michigan, within the last two or three days, I raised the question of an additional form of certification, and this I did for the reason that many men have asked for some special qualifying certificate other than that given for attendance. They have both agreed that after a period of four years' attendance both schools will make available an examination on the content of the four-year course, and on successfully passing that examination the candidate will be given a certificate of proficiency from the University.

Now, we have not decided yet whether that will be a composite certificate—that is, one coming from both universities—or the candidate will have to go to one or the other. In any event, the examination will be identical, and it will be formulated by a member of the faculty of Wayne University College of Medicine, by a member of the faculty of the University School of Medicine, and a member from the State Society. I think that is a distinct advance in recognition for an improved quality of service on the part of the individual.

I was thinking this morning of the history of our

efforts in postgraduate education. They extend now over about twenty years. It leads one to believe that anything that is worth while is going to take quite a long time to accomplish.

We have now in Michigan a well-planned postgraduate program in the State Society which has taken twenty years to develop. The Michigan Medical Service Plan, just inaugurated, has taken something in excess of ten years to develop. So one might generalize and say that anything that is worth doing is worth devoting ten years to develop.

I don't think there is anything more to add to this. Most of the factual data will be found in the short report that I gave you.

THE SPEAKER: This committee will be referred to the Reference Committee on Standing Committees.

VIII-7. PUBLIC RELATIONS COMMITTEE

Dr. Foster informs me that the Public Relations Committee has nothing further to report, other than the report in the Handbook. The Report of the Public Relations Committee will be referred to the Reference Committee on Standing Committees.

VIII-8. ETHICS COMMITTEE

H. W. PORTER, M.D. (Jackson): Mr. Speaker, I would like to announce there is nothing that has to be added to the report as published in the Handbook.

THE SPEAKER: The Report of the Ethics Committee will be referred to the Reference Committee on Reports of Standing Committees.

VIII-9. PREVENTIVE MEDICINE COMMITTEE

L. O. GEIB, M.D. (Detroit): The Report of the Committee on Preventive Medicine is in the Handbook. The only supplementary report would be that the Committee had a meeting yesterday, at which time consideration was given and the supplementary reports on Maternal Health, Child Welfare and Tuberculosis were ratified.

THE SPEAKER: The Report of the Preventive Medicine Committee will be referred to the Reference Committe on Standing Committees.

VIII-10. CANCER COMMITTEE

The Cancer Committee report as printed in the Handbook is referred to the Reference Committee on Standing Committees.

VIII-11. COMMITTEE ON IODIZED SALT

FREDERICK B. MINER, M.D.: Mr. Speaker: Last February the chairmanship of the Iodized Salt Committee came to me by the untimely death of Dr. Cowie. As you all know, Dr. Cowie had championed the Committee for seventeen and one-half years. He gave it much study and a great deal of work. In his private laboratory, he continuously checked up on samples of iodized salt, and to him we owe all credit for the establishment and the bringing out to the profession of the state and to the profession of the United States our iodized salt.

The "Battle of Washington" just happened in April, when I happened to be in Washington and consulted with the Federal Food and Drug Administration. To my great amazement, I found that we had almost lost iodized salt in the previous January. If it had not been for Dr. Thomas Parran's department, it would have been wiped off the slate, but he saved the day for further consideration, and in April we found already published on March 28 in the Federal Registry, such restrictions on iodized salt that it would have been defeated in a short time.

Fortunately, the President's executive order, changing the Department of Food and Drugs from the Agricultural Department to the Federal Security Agency, gave us ample time to get in our oars, and also nullified the publication of the Federal Registry and the public hearing which was to have taken place on April 29. Had that hearing gone through and been unattended by any member of the Michigan Society, the salt producers would have been compelled to use on the labels of iodized salt a defeatist statement. If you notice, now on the present labels no therapeutic statement is made. It is simply "IODIZED SALT." The fight before the Administration is to reëstablish a simple statement that "IODIZED SALT PREVENTS SIMPLE GOITER." Your House of Delegates authorized this Committee in 1923 to ask for such a statement, and it has been used continuously since that time. We feel that it has been the major factor in educating the public and possibly the profession in the use of iodized salt, and such a statement should be continued on the label. We feel that the consumer and the retailer have a right to know why salt is iodized.

When iodized salt first came before the Federal Food and Drug Administration, the immediate question was, "Why is a poison added to a commodity which is used so generally as salt?" In spite of figures, statements, and results, they still maintained their attitude not to allow a therapeutic statement on the label. However, with due pressure, through the Surgeon General's Department, we have been assured that it can be reëstablished on the label. But we have no statement from the Food and Drug Administration as yet that they are giving us that authority.

In behalf of the Iodized Salt Committee, I wish to convey its appreciation for the timely action of your Executive Committee and the Council and their assistance in supporting the Committee's recent urgent action with the Federal Food and Drug Administration and Surgeon General Parran's Department.

I am sure that the tribute this morning was quite undeserved. Any committeeman finding himself in a similar predicament would have done as much or more than I have done in saving iodized salt for our state.

Mr. Speaker, I wish to add a report of the Child Welfare Committee.

VIII-12. CHILD WELFARE COMMITTEE

The fifth meeting of this committee was held on August 28, subsequent to the rendering of the report that appears in the Handbook.

It is felt that the State Medical Society, through this Committee, has a very definite responsibility to acquaint itself with the medical procedures and standards in all of our child-caring institutions, and in turn to render all desirable aid and support possible. The dean at the school for the deaf, since our visit there last January, has expressed much appreciation for the suggestions given at the time of our visit last January.

Supplementary Report—Child Welfare Committee

Dr. A. H. Whittaker, Chairman of the Child Welfare Committee of the American Legion, presented a resolution for our consideration, which came from their committee and was subsequently passed by the Legion's Convention. In substance it is "to create a Study Commission which, after careful study and research, will bring a report and recommendation to the State Legislature for the enactment of a Children's Code which will supersede all existing statutes for the care and protection of children, and which will provide an orderly basis for guarding our state's most valuabe asset, our children." The suggested group to be made up of representatives from the following associations:

American Legion
Michigan State Medical Society

Michigan Branch of the American Academy of Pediatrics
Michigan Society of Orthopedists
Michigan State Department of Health
Michigan Hospital Association
Michigan Physiotherapists Society
Crippled Children's Commission
Michigan Welfare League

It is hoped that the Council and House of Delegates will concur in the Committee's action of endorsement and if the State Society is called upon by the new commander it will lend its fullest coöperation. The Legion has three hundred and fifty-three local child welfare committees and can be of material assistance.

In behalf of the Iodized Salt Committee I wish to convey its appreciation for the timely action of your Executive Committee and Council for their assistance in supporting the Committee's recent urgent action with the Federal Food and Drug Administration and Surgeon General Parron's department.

The problems of your Child Welfare Committee are many and varied; i.e., custodial care, up-to-date procedures in preventive medicine, and state remedial medicine. The field is large; the program of this Committee should be everlastingly progressive. In order to visit state institutions caring for children, and in order to keep abreast with, and to be the medical mentor to, the State Parent-Teacher organization and the State Department of the American Legion, much study and time will be required. This committee is going to need a full-time secretary if adequate and creditable work is to be done. Busy practitioners cannot afford the necessary time. Both of the lay organizations have such secretaries in their Child Welfare Departments. The surface this first year has barely been scratched.

THE SPEAKER: The Reports of the Child Welfare Committee and the Iodized Salt Committee will be referred to the Reference Committee on Reports of Standing Committees.

VIII-13. HEART AND DEGENERATIVE DISEASES

Next we have the Report of the Committee on Heart and Degenerative Diseases as published in the Handbook, which will be referred to the Reference Committee on Standing Committee Reports.

VIII-14. MENTAL HYGIENE

The Mental Hygiene Committee report as published in the Handbook will be referred to the Reference Committee on Standing Committee.

VIII-15. SYPHILIS CONTROL COMMITTEE

R. S. BREAKEY, M.D.: The Report of the Syphilis Control Committee is found on page 59 of the Handbook. There is only a brief supplementary report.

The Syphilis Control Committee wishes to endorse, in the sense of an additional report, the resolution submitted by Dr. Valade, a member of this Committee, this morning.

THE SPEAKER: The Report of the Syphilis Control Committee will be referred to the Reference Committee on Standing Committees.

VIII-16. INDUSTRIAL HEALTH COMMITTEE

HENRY COOK, M.D.: I do not wish to add anything to what is in the Handbook, but I would like to emphasize one point which it seems to me is not quite generally understood enough among the various county medical societies. They have a feeling that the work of industrial health has to do with industrial accidents which occur in industry, which is largely the responsibility of industry to take care of. Industry is making a study at the present time of the health condition of its workers and of those diseases which arise out of the ordinary illnesses but which affect his employment, and they are looking to the medical profession, the private practitioner, the private physician, to assist and coöperate with them in the correction of these things. Ninety per cent of the lost time in industry results from those diseases, and there is a great opportunity for the medical profession to take care of that work, which rightfully belongs to it, if it will take cognizance of that fact and coöperate with industry in the care of ordinary illnesses which have to do with lost time.

So I would like to emphasize that you men take back to your counties that one fact. If we do not pay attention to it, we are losing an opportunity. If we do, we are meeting our responsibility, and it is to our own advantage to do that.

THE SPEAKER: The Report of the Industrial Health Committee will be referred to the Reference Committee on Standing Committees.

VIII-17. TUBERCULOSIS CONTROL COMMITTEE

The Report of the Tuberculosis Control Committee as printed in the Handbook will be referred to the Reference Committee on Standing Committees.

The Speaker understands there is one further resolution which has not been offered, so I will at this time entertain a motion to revert to the previous order of business.

PAUL KNISKERN, M.D. (Kent): I move that we revert to the previous order of business.

The motion was seconded and carried.

VII. Amendments to Constitution

VII-2. PROPOSED AMENDMENT TO CONSTITUTION RE PAST PRESIDENTS

B. B. BUSHONG, M.D. (Grand Traverse-Leelanau, Benzie): This is a resolution to amend the Constitution:

"BE IT HEREBY RESOLVED that Article IV, Sections 1 and 2 of the Constitution be amended to provide for the retention of Past Presidents as Delegates at Large with power to vote."

THE SPEAKER: The resolution offered by Dr. Bushong will be referred to the Reference Committee on Constitution and By-laws.

THE SPEAKER: May we have a motion to revert to the usual order of business, please?

Upon motion regularly made, seconded and carried, the meeting reverted to the usual order of business.

THE SPEAKER: We will now take up the reports of special committees. The first report will be the report of the Committee on Nurses' Training Schools.

IX. Reports of Special Committees

IX-1. COMMITTEE ON NURSES' TRAINING SCHOOLS

A. L. ARNOLD, M.D.: The complete report is in the Handbook. We suggest that the committee be continued, for further study.

THE SPEAKER: The report of this committee will be referred to the Reference Committee on Reports of Special Committees.

IX-2. CONFERENCE COMMITTEE ON PRE-LICENSURE MEDICAL EDUCATION

This report will be referred to the Reference Committee on Reports of Special Committees.

IX-3. MEMBERSHIP COMMITTEE

This report will also be referred to the Reference Committee on Reports of Special Committees.

IX-4. RADIO COMMITTEE

J. DUANE MILLER, M.D.: The report is printed in the Handbook. Some twenty-four programs were prepared and broadcast over twelve stations during the winter period, and in addition a few rebroadcasts were requested and granted after consultation with the President of the State Society.

I want to emphasize two of the recommendations which our committee has made. The first two, of course, are purely technical and are made in the interest of succeeding committees.

The third is that the State Society and/or the Joint Committee on Health Education should set up some method for evaluating these programs. That suggestion was made because we have had various rumors about the value of different types of programs, and there seems to be no policy established for the preparation of these programs; that is, the type of program to be broadcast or the time of day or the time of year it is used.

Lastly, we think some effort should be made to coordinate the radio programs on medical subjects that are now broadcast by the University of Michigan, the Wayne County Medical Society, and those sponsored by the Joint Committee and provided by the Radio Committee of the State Society. There has been a great deal of overlapping and no one knows what the other is doing. I think it is time for those organizations to coordinate their programs in such a way as to avoid overlapping and repetition.

THE SPEAKER: The Report of the Radio Committee will be referred to the Reference Committee on Reports of Special Committees.

IX-5. ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY

This report of the Advisory Committee to the Woman's Auxiliary will be referred to the Reference Committee on Reports of Special Committees.

IX-6. SCIENTIFIC WORK COMMITTEE

I think evidence of that will be found during the following days of this session.

THE SPEAKER: We will now recess until three o'clock.

The meeting recessed at twelve-thirty o'clock.

Tuesday Afternoon Session
September 24, 1940

The Second Session was called to order at three-twenty o'clock, Dr. Stryker presiding.

THE SPEAKER: The afternoon session of the House of Delegates is now declared in order.

We will have the supplementary report of the Committee on Credentials.

E. O. Foss, M.D.: We have sixty-five registered delegates. That constitutes a quorum.

THE SPEAKER: A quorum is present. The report of the Credentials Committee will constitute a roll call.

GEORGE SOUTHWICK, M.D. (Kent): I move that the House go into executive session.

The motion was seconded and carried.

The House of Delegates considered several matters in executive session.

WILLIAM ELLET, M.D. (Berrien): Mr. Speaker, I move we rise from executive session.

The motion was seconded by several, put to a vote and carried.

THE SPEAKER: Dr. Foster has a communication which he will read.

X-2. MEDICAL CORPS U.S.N.

SECRETARY FOSTER: Mr. Speaker and Members of the House: This is a rather lengthy communication that has been called to our attention in the last few hours by the Medical Department of the United States Navy. It is a little bit lengthy, but they have rather felt it was important that this information, which is new, be brought to this group now. This was given to me by Lieutenant Commander J. E. Malcomson, Medical Corps, United States Navy, and is as follows.

Secretary Foster read the communication from the Navy Department, outlining the opportunities in the Medical Corps of the Navy for physicians.

X-3. UNSATISFACTORY CONVENTION ACCOMMODATIONS

WILLIAM ELLET, M.D. (Berrien): I note that there is no place on the program for the selection of a meeting place for next year. It has been the custom of this Society to alternate between Grand Rapids and Detroit. The accommodations in Detroit this year are terrible. I think there isn't a member from out of the city but has had difficulty in getting his room. There are three conventions in this hotel at this time. This room should have been emptied at twelve o'clock so that four hundred women outside here could come in.

Now, I don't know how to express this, whether in a resolution or not, but I feel it should be taken up by The Council, as long as it has been left in their hands before, that unless Detroit can make better arrangements for a convention two years from now, our convention should not be held here but in Grand Rapids.

I would like to hear any comment the Speaker might have to offer.

THE SPEAKER: The Speaker deplores the lack of accommodations as much as any member of the House of Delegates.

In fairness to the Executive Secretary, I know that he had made all plans and that we had received assurances from the management, both of the Book-Cadillac Hotel and the Convention Bureau, that we would have exclusive convention privileges here at this time, but they just haven't lived up to their promises.

If there are any more remarks to be made by the House on the same subject, this is your opportunity.

DR. ELLET: Mr. Speaker, might I ask if there is someone here from Wayne who has any objections to offer to my suggestion

R. L. NOVY, M.D. (Wayne): Mr. Speaker, the delegates of Wayne are always glad to go out of town for conventions, rather than stay in town.

THE SPEAKER: Perhaps it would be good to hear from the delegates of Kent.

C. F. SNAPP, M.D. (Kent): Mr. Speaker, we always enjoy coming to Detroit to meetings, but the accommodations this year have certainly been deplorable. The idea of a hotel putting up three or four conventions! I understand there are three here at the same time. It is impossible for them to care for all at once. I know what you are up against.

We have no official authorization to invite you to Grand Rapids, but the delegation here from Kent was saying a while ago that we would be very glad to invite you up there for at least three years or more. We will give you an excellent meeting place, as you know from past experience, and we have plenty of space for exhibits. The exhibit space here, I think, is terrible, and I know the Society loses out on a lot of income because of the lack of space. We have an unlimited amount of it in Grand Rapids. We will be glad to have you in Grand Rapids as long as you like to stay.

DR. ELLET: I have been authorized by the Mayor of Benton Harbor to invite the Michigan State Medical Society to hold its convention in Benton Harbor two years from now, with this exception—we cannot provide you space for your exhibits. We can provide you excellent hotel accommodations, and we can give you plenty of meeting rooms. That should be considered.

L. J. HIRSCHMAN, M.D. (Wayne): I agree with my colleagues of Wayne that we would like to go out of town for a meeting, and I do not know of a nicer

place to go than Grand Rapids. I go to Grand Rapids every year. But I want to say this one word. I believe you gentlemen who have come to meetings in Detroit in previous years have never run up against this experience you have had this year. We all feel very bad about it, because we want to be your host many, many times in the future.

I felt so disturbed about it that I telephoned the Convention Bureau this morning. I don't think the person at the other end heard all I said, because the wires melted from my heat. I found out that Lee Barrett, the President of the Convention Bureau, and his chief assistant, Mr. Sedan, are both in Boston at the Legion Convention. The man who is next in command I have asked to come over here to the hotel this afternoon and just see what you fellows are up against, and move around among you and ask some questions and find out your complaints, and then as an authorized member of the Convention Bureau to take it up with the hotel. I did that on my own responsibility, and he will be here later this afternoon. I hope you will tell him your story.

THE SPEAKER: It might be well to repeat again that these reservations for the officers, delegates, and all others were made last fall, and we have in the files in Lansing a letter, under date of October 21, 1939, in which there is definite assurance given that there would be no other convention in the Book-Cadillac Hotel at this time.

Does anyone wish to make a motion or refer this to The Council for further action? They probably know your attitude.

FRANK A. REEDER, M.D.: Mr. Speaker, I move that it be referred to The Council for further action.

The motion was seconded.

HENRY R. CARSTENS, M.D.: As a resident of the city, my face is equally pink. The Council has already taken up the matter. They started taking it up last night. As Dr. Hirschman said, one or two of the key men of the Convention Bureau were not here. What the full facts are, we do not know, but we think we will know tomorrow.

The Council does not yet know what the full facts are, but has already taken steps.

THE SPEAKER: We will now have a vote on the question. All in favor say "aye"; opposed the same. The motion is carried.

VI-3. SPECIAL MEMBERSHIPS

C. E. Toshach, M.D., Saginaw, read a resolution recommending that Dr. W. J. O'Reilley of Saginaw be made an Emeritus Member.

THE SPEAKER: The Resolution will be referred to the Reference Committee on Resolutions.

R. S. BREAKEY, M.D. (Ingham): I wish to ask a point of order. We wish to offer an amendment to the resolution offered by Dr. Valade this morning. It has passed to the Reference Committee. We approve it in principle. Is that amendment to be offered now or after the Report of the Reference Committee?

THE SPEAKER: I think the amendment should be made after the Report of the Reference Committee.

XI. Reports of the Reference Committees

XI-1. ON OFFICERS' REPORTS (I, II, III, V)

E. A. OAKES, M.D.: This Committee has to consider as officers' reports, the Speaker's Address, the President's Address, the President-Elect's Address, and the reports of the Delegates to the A.M.A. We have a very brief report for your consideration and for your action.

* * *

Your Committee on Officers' Reports appreciates the scope and extent of these reports, which included the Speaker's address, the President's address, and the President-Elect's address; and wishes to recommend these to the House of Delegates with their approval.

The Committee wishes to give special recommendation to the suggestion of President Corbus for contacting senior students regarding early affiliation with their county and state societies, believing this to be an important step in their early training as efficient members of the medical organization.

Likewise we recommend the splendid report of the Delegates to the American Medical Association and commend the report to you for full reading.

(Signed) E. A. OAKES, M.D., Chairman, A. T. HAFFORD, M.D., A. E. STICKLEY, M.D., R. C. JAMIESON, M.D., G. H. YEO, M.D.

I move the adoption of this report.

The motion was seconded, put to a vote and carried.

XI-2. ON COUNCIL REPORTS (IV and VI-6)

THE SPEAKER: Report of the Reference Committee on Reports of The Council. Dr. Pino.

RALPH H. PINO, M.D.: Considering the extensive amount of work done by The Council, we can offer only our congratulations and thanks. We have made some changes in the section having to do with a public relations activity, the resolution to read as follows:

Resolutions Re Public Relations

WHEREAS, The Council of the Michigan State Medical Society, as the result of a careful and thorough study of the need for sustained public relations with the people, realizes that due to an increasing number of social, economic and legislative problems relating to public health, medical care and the practice of medicine, an increasing need exists at the present time for the maintenance by the Michigan State Medical Society of a strong and active statewide Public Relations Department, and

WHEREAS, Even with splendid coöperation from the press and the radio of Michigan, for which the medical profession expresses its sincere gratitude, it is desirable to maintain a closer and more harmonious relationship between the medical profession and the people, and

WHEREAS, This can be accomplished by a well planned program of public relations worked out on a long range basis—a program embodying an efficient and effective press relation, an expanded radio program, increased legislative effort, an enlarged speakers' bureau and other worthwhile public contact activities, therefore be it

RESOLVED, That this House of Delegates authorize The Council and its Executive Committee to proceed with the development of such a public relations activity in the Executive Office of the Michigan State Medical Society, and that The Council be authorized to provide the necessary funds for the establishment of such a necessary activity and the employment of a Public Relations assistant in the executive office.

We have discussed every section of The Council report pro and con. We have listened to extensive argument. We are unanimous in recommending the adoption of the complete report. Mr. Speaker, I so move.

Respectfully,
COMMITTEE ON REPORT OF THE COUNCIL.

The motion was seconded by Dr. Paul Kniskern of Kent, put to a vote and carried.

XI-3. ON STANDING COMMITTEE REPORTS
(Legislative Committee, VIII-2)

EDWARD D. SPALDING, M.D.: The first report is the Annual Report of the Legislative Committee, a tremendously important and hard-working committee. There are important comments about the necessity of not burdening the Legislative program in a year when combative measures against cult legislation are the most important matter.

The Committee entirely endorses this report, and I move its adoption.

The motion was seconded, put to a vote and carried.

XI-3. ON STANDING COMMITTEE REPORTS

(Representatives to Journal Committee on Health Education, VIII-3)

DR. SPALDING: The report of the Representatives to Joint Committee on Health Education is also endorsed in its entirety. I move its adoption.

The motion was seconded by G. C. Penberthy, M.D., of Wayne, put to a vote and carried.

XI-3. ON STANDING COMMITTEE REPORTS

(Cancer Committee, VIII-10)

DR. SPALDING: I will next take up the Annual Report of the Cancer Committee, which is endorsed, and I move its adoption.

The motion was seconded by E. A. Oakes, M.D., of Manistee, put to a vote and carried.

XI-3. ON STANDING COMMITTEE REPORTS

(Preventive Medicine, VIII-9)

DR. SPALDING: The Report of the Preventive Medicine Committee is also endorsed, and I move its adoption.

The motion was seconded by A. V. Wenger, M.D., of Kent, put to a vote and carried.

XI-3. ON STANDING COMMITTEE REPORTS

(Tuberculosis Control Committee, VIII-17)

DR. SPALDING: The Report of the Committee on Tuberculosis Control is brief, and is also endorsed, and I move its adoption.

The motion was seconded by C. E. Simpson, M.D., of Wayne, put to a vote and carried.

XI-3. ON STANDING COMMITTEE REPORTS

(Syphilis Control, VIII-15)

DR. SPALDING: The Report of the Syphilis Control Committee consists in the report as published in the Handbook, of some four pages, together with a resolution introduced this morning on the floor.

The report, as published in the Handbook, without the resolution, is endorsed, and I move its adoption.

The motion was seconded by R. C. Jamieson, M.D., of Wayne, put to a vote and carried.

XI-3. ON STANDING COMMITTEE REPORTS

(Resolution on Genito-Infectious Disease Program, VI-1)

DR. SPALDING: In this connection, Dr. Valade read a resolution this morning pertaining to the question of syphilis control and the treatment of disease. The Committee understands there has been some discussion in the Syphilis Committee on the wording of some of the final paragraphs of this resolution and that possibly a change will be offered from the floor at this point. The spirit of the resolution, as read this morning, is endorsed by the Committee. If there is any further change in the reading of the resolution as presented, it should come from the floor at this time.

R. S. BREAKEY, M.D.: I move an amendment to the resolution as read.

DR. SPALDING: The first half of the resolution is to be left as such. Possibly it would clarify the situation a little bit if I read the resolution, the last half of the resolution as presented this morning, and then read the rewording.

This is the resolution as presented this morning.

RESOLVED, That it is the sense of this House of Delegates that such coöperation on the part of the medical profession should be freely extended and that the official health agencies, state and local, charged with the administrative responsibilities for the conduct of the program be urged to formulate plans and machinery with the assistance of the Syphilis Control Committee of the Michigan State Medical Society for as full utilization as possible of such numbers of the local medical profession as are willing and competent to undertake the clinical management of such programs; and be it further

RESOLVED, That it is the sense of this House of Delegates of the Michigan State Medical Society that component county societies should coöperate fully in the effort to improve the quality of services to be rendered in genito-infectious disease control programs; and be it further

RESOLVED, That it is the sense of this House of Delegates of the Michigan State Medical Society that because of the potential dangers of intravenous therapy, such medication should be administered only by a duly qualified doctor of medicine.

That is as it was given to you this morning.

This is the substitute resolution, after the preamble:

(DR. Spalding read the substitute resolution. See page 883.)

The Committee has unofficially considered the revised version and has officially considered the original resolution. It is more or less a question of forcefully expressing the same idea.

THE SPEAKER: The Speaker rules that this resolution should be sent back to the Reference Committee and reported on at tonight's session.

XI-3. ON STANDING COMMITTEE REPORTS

(Postgraduate Medical Education Committee, VIII-6)

DR. SPALDING: The Report of the Committee on Postgraduate Medical Education shows an enormous amount of excellent work, giving the programs of both the current year and the proposed program in the year to come. It is quite astounding that the medical attendance in this state represents somewhat more than 50 per cent of the roster of the State Society.

We heartily endorse this report and move its adoption.

The motion was seconded by C. T. Ekelund, M.D., of Oakland, put to a vote and carried.

XI-3. ON STANDING COMMITTEE REPORTS

(Public Relations Committee, VIII-7)

DR. SPALDING: The Report of the Public Relations Committee is brief and to the point, and has three recommendations. The committee endorses the report and these recommendations, and I move its adoption.

The motion was seconded by S. L. Loupee, M.D., of Cass, put to a vote and carried.

XI-3. ON STANDING COMMITTEE REPORTS

(Ethics Committee, VIII-8)

DR. SPALDING: We endorse the Ethics Committee report, and I move its adoption.

The motion was seconded by C. E. Simpson, M.D., of Wayne, put to a vote and carried.

XI-3. ON STANDING COMMITTEE REPORTS

(Medical-Legal Committee, VIII-5)

DR. SPALDING: The Report of the Medical-Legal Committee is endorsed, and I move its adoption.

The motion was seconded by J. A. Wessinger, M.D., of Washtenaw, put to a vote and carried.

XI-3. ON STANDING COMMITTEE REPORTS

(Maternal Health, VIII-1)

DR. SPALDING: The Report of the Committee on Maternal Health gave us most gratifying and surprising information about the low mortality rate in small

hospitals. There are no recommendations made. The report is endorsed, and I move its adoption.

The motion was seconded by Dr. Ellet of Berrien, put to a vote and carried.

XI-3. ON STANDING COMMITTEE REPORTS

(Child Welfare Committee, VIII-12, and Iodized Salt Committee, VIII-11)

DR. SPALDING: The Report of the Child Welfare Committee, together with the subcommittee report on Iodized Salt. The committee is to be immensely complimented on its work in Washington, in which they have apparently been able to reinstate the therapeutic label.

The committee moves the adoption of this subcommittee's report on Iodized Salt. This comes as a part of the report of the Child Welfare Committee as a whole, which is printed in the Handbook, a page and a half, together with the supplementary report given to you this morning. Both the original report as printed and the supplementary report as given this morning are endorsed. I move the adoption of the entire report of the Child Welfare Committee.

The motion was seconded by Donald R. Brasie, M.D., of Genesee, put to a vote and carried.

XI-3. ON STANDING COMMITTEE REPORTS

(Heart and Degenerative Diseases, VIII-13)

DR. SPALDING: The Report of the Committee on Heart and Degenerative Diseases is endorsed, with a single exception of this statement, "The upper limit of normal blood pressure is much lower than formerly supposed and is now considered 130 mm. systolic." The committee feels that such dogmatic statements should not appear in this report, and it is deleted. With that exception, the report is endorsed as it is written, and I move its adoption.

The motion was seconded by C. E. Dutchess, M.D., of Wayne, put to a vote and carried.

XI-3. ON STANDING COMMITTEE REPORTS

(Industrial Health Committee, VIII-16)

DR. SPALDING: The Report of the Committee on Industrial Health is endorsed, and I move its adoption.

The motion was seconded by T. E. Hoffman, M.D., of Tuscola, put to a vote and carried.

XI-3. ON STANDING COMMITTEE REPORTS

(Mental Hygiene, VIII-14)

DR. SPALDING: The Report of the Committee on Mental Hygiene is endorsed, and I move its adoption.

The motion was seconded by G. C. Penberthy, M.D., of Wayne, put to a vote and carried.

XI-3. ON STANDING COMMITTEE REPORTS

(Distribution of Medical Care, VIII-4)

DR. SPALDING: On the Report of the Committee on the Distribution of Medical Care, there was prolonged and quite intense discussion by the Reference Committee. The Reference Committee feels they cannot endorse the statements of the Committee on the Distribution of Medical Care on the matter of liberalization of the requirements of specialty boards as a whole. We feel the educational requirements of the specialty boards are not too high, but that the fault lies in the fact that these requirements may be so applied as to unfairly exclude certain qualified physicians and thus create a virtual monopoly.

With this exception, your committee recommends the adoption of this report.

THE SPEAKER: Is there any support to that?

The motion was seconded by Dr. Dutchess of Wayne.

THE SPEAKER: It has been moved and supported that the report of this committee be adopted. Are there any remarks?

G. L. MCCLELLAN, M.D., (Wayne): Are we to understand that the section read by Dr. Spalding has been deleted from the report?

THE SPEAKER: That is the way I would rule.

DR. MCCLELLAN: They do not approve of the statement that the Specialty Board's requirements are now too high?

THE SPEAKER: That is right.

Are there any further remarks?

H. H. LUCE, M.D., (Wayne): In all due respect to the Chairman of that Committee, I don't know just what he means.

THE SPEAKER: Will Dr. Spalding explain what he means?

DR. SPALDING: Dr. Luce, I have been called many things in my life, but ambiguity is not one of them, ordinarily.

Possibly it will clarify the situation if I read one or two excerpts from this report.

The Committee on the Distribution of Medical Care, in submitting this report, makes no recommendations to the House of Delegates, but they did pass a resolution, which they forwarded to The Council for their action during the year.

They narrate in the body of the report that considerable discussion occurred during the year, particularly on the situation in Genesee County, and, quoting from the report—

> "This discussion was summed up into two points:
> "1. Specialty Boards have too rigid requirements.
> "2. Lay groups must be impressed that there are qualified physicians who are not members of the specialty boards."

The committee discussed this at great length, and with a good deal of unanimity. It felt that it was a rather extraordinary statement to make, that lay groups must be impressed by the fact that there were qualified physicians who were not members of these various boards. I don't know why the State Medical Society should take it upon itself to impress the laity with information of this sort, particularly as the purpose of a specialty board is to increase the quality of medical education and medical practice in the country.

Going on to the fine print at the end of their report, in which they quote their resolution, which they have forwarded to The Council:

> "The selection, by lay boards dealing with crippled and afflicted persons, of specialists designated as such by the various Medical Specialty Boards, has served to dislocate the orderly practice of medicine so that physicians qualified by years of experience are denied the privilege of rendering service."

Parenthetically, I might remark that just because one has had fifty years of service at the bedside without a death does not qualify a person as a specialist in that disease. To continue with the report to the Council:

> "Any movement looking toward better medicine and surgery for the public must be applicable to the profession as a whole and not to only a chosen few if there is to be any general support for the movement."

If you are attempting to make specialists of the entire profession, then I do not know what the meaning of "specialization" is.

Going on with the quotation:

> "THEREFORE, BE IT RESOLVED, That action be initiated towards a liberalization of requirements as set by the various specialty boards so that the factor of experience be given its due weight in the qualification of candidates for license from these specialty boards.
> "The committee suggests to The Council that it instruct our delegates to the A.M.A. to bring this matter to the attention of the House of Delegates of the A.M.A. at its next annual meeting."

There are seventeen specialty boards, and the great majority of these are functioning effectively and with very little fuss. The particular thing that is a tempest in a teapot concerns the orthopedic situation in the State of Michigan, particularly. There may be some other exceptions, but that is the most important one. To damn the specialty boards as a whole on account of a rumpus that has been aroused because of certain highly specialized work in one particular department is highly unfair to this whole movement, which the Reference Committee feels is a very laudable movement, and it is on that account that we have made the particular recommendations.

You understand that your Committee on the Distribution of Medical Care, although they forwarded a resolution to The Council, have made no recommendations to the House of Delegates. They are merely expressing their opinion, and we in turn, as a Reference Committee, are expressing our opinion of their opinion.

RALPH H. PINO, M.D. (Wayne): Could we hear their opinion again? You have arranged the report. Do I understand that right?

THE SPEAKER: No, in this case, Dr. Pino. They have merely deleted a certain portion of the report, that portion concerned with the requirements of specialty boards.

DR. PINO: It seems to me then that this Reference Committee should try to understand and clarify that situation. I am thoroughly in accord with the specialty boards, but certain situations arise. We cannot just shut off the criticism that comes from men who do not happen to have been admitted to these boards, some of them definitely older men.

I think Dr. Spalding is entirely right in saying that we should not deride the high standards of the boards, but I do think we should pass by the request of men doing special work, who perhaps have gone long past the years when they feel they could pass that board, and when they are saying that they feel they should be able to fill out that blank. I think it would be likely that we would work them into the service if we needed them to take visions, if we were, let us say, recruiting soldiers.

I wish this Reference Committee would understand and say that the spirit of the Committee on the Distribution of Medical Care in recommending this was correct.

D. R. BRASIE, M.D. (Genesee): This question does not involve specifically the orthopedic situation in Genesee County. It is a broader question than that. We found last year that the rank and file of general practioners in Genesee County could not certify to the School Board that a child they had taken care of since birth had a heart condition; it must be certified by a registered, qualified cardiologist. There are none in Genesee County. The point is not whether the specialty boards have a function and a place. They came in to properly qualify specialists. I don't think there is any quarrel about that. However, the quarrel seems to be as to how these men shall be qualified.

Now I speak not only for some of the older men, who by reason of the fact of economic circumstances or any other reason, were unable to spend three to five years in postgraduate study in a teaching institution and thereby qualify to a specialist board; I also speak for these men who have not as yet entered the study of medicine. Many of the men who are now at the head of the specialty boards did not serve any extended period of internship. Where did they get their training and their experience that put them there? From sixty years bedside service, without the loss of a patient.

There are two ways to qualify and gain knowledge. One is, by preference, if you please, three to five years extra training in the university or teaching institution. We would all prefer that, could we have it, but there are many very bright men in medicine who, if the specialty boards are allowed to require that and require that solely, will never attain the position they should. I speak for the men as yet coming into medicine, who will not have the money to spend on these years of training.

Now, you have already set up a postgraduate training course in the State of Michigan. If that course is to amount to anything except a sop to the general practitioner, if these certificates that are being passed out are going to mean anything except another piece of writing, then you must provide in your teaching institution ways and means by which a man who can not spend three to five years entirely in a teaching institution may attain the knowledge and the requirements to qualify him as a specialist. That can be done through your specialist training, through your postgraduate training, and through adequate examinations by these same people who teach the men for three to five years.

It says in most of the requirements of the specialty boards that they will accept three to five years special training or its equivalent. If they will accept its equivalent and if they will establish an equivalent fair and square, that an individual who is out ten years can meet, then they have been fair and have fulfilled the functions, and they will admit into their body, rightly and justly, men who have acquired their training outside of teaching institutions.

T. K. GRUBER, M.D. (Wayne): Mr. Speaker, I think the wording of the report has missed the boat, in what they intended to say. So far as the specialty boards are concerned, I am very much in agreement with them. On the other hand, when it comes to the application of the principle that a man must have passed a specialty board, just as Dr. Brasie said, in whatever county he lives, they do not have any heart specialists that have passed the board. In many of the counties there are no psychiatrists who have passed the board. If we were to decide that no person could be judged insane unless a man who had passed the Specialty Board of Psychiatry had passed on him, we would have very few people judged insane in Michigan. So it is with many of the other specialty boards.

I do not think we are in position in this country yet —and maybe we never will be—to apply the rule that if a man is going to give an opinion on a heart, on a mind, on a broken bone or something else, he must have passed a specialty board. It is all right to say that man is a specialist because he has passed the board and all that, but if you start to apply this thing, you have the whole works gummed up. I just don't think we are ready for it, and I think we are trying to get the cart just about two miles ahead of the horse.

I believe the specialty boards are all right. There are admittedly, by the man in Wayne County, so I am told, some eight hundred specialists on all the various branches. How many of those men are specialists, I don't know. On the other hand, I don't care what county you go in, outside of the largely populated counties, you will find very few men who have passed any of the specialty boards.

THE SPEAKER: The Chairman of the Reference Committee has the floor.

DR. SPALDING: Most of us are looking a good deal more eye-to-eye on this problem than would seem to be the case from the discussion that has come up. The point is that we are trying to get it down on paper to express what most of us really mean. I do not differ with Dr. Brasie or with Dr. Gruber anywhere near as much as it seems on the surface.

If you will listen to this one sentence, I think you will see that the Reference Committee has tried to embody this in their statement: "We feel that the educational requirements of the specialty boards are not too high, but that the fault lies in the fact that these

requirements may be so applied as to unfairly exclude certain qualified physicians and thus create a virtual monopoly."

In other words, we want to leave the boards and their high standards as they are, but if you don't need that high bit of standardization, then you can take another standard of qualification. That is what we are trying to get across, not to condemn or lessen the qualifications of the specialty boards.

C. E. TOSHACH, M.D. (Saginaw): I think we all ought to think about what Dr. Cummings said a few minutes ago. The reason these men have to go to these different towns and pass the specialty board is not because those towns want them to do so; it is because the federal funds that help to pay the expense demand that the man who is on the board be called. The federal funds are not given unless the man is passed by the board. If we do not want to continue such a government, we have an election in November.

P. L. LEDWIDGE, M.D. (Wayne): As a member of the Reference Committee, I would like to remark that I think the Reference Committee has done as much as it can on this. No recommendations were made. Is it not right that the Reference Committee can only review what has been done and not bring in new recommendations?

Now, what we did was simply to go over this. We did not agree with all of it. We had some other thoughts along the same line, and we simply added that to what was already there. I believe that is complete so far as the work of the Reference Committee is concerned, and that, with these other thoughts that have been expressed here, can be taken into consideration by our delegates to the A.M.A. There are no recommendations. Therefore, I don't see how any action can be taken other than that.

DR. GRUBER: Mr. Speaker, I move that this report be returned to the Reference Committee.

THE SPEAKER: There is already a motion before the House.

THE SPEAKER: The question has been called for. Does everyone understand the question?

Upon a request from the House, the Speaker read the recommendation of the Reference Committee.

THE SPEANER: The motion was made for the acceptance and adoption of that report, and that was supported. That is the question before the House. Now you have heard the question. All in favor of the question say "aye"; opposed the same.

The motion is lost.

HENRY LUCE, M.D. (Wayne): Mr. Speaker, I move that that matter be again referred to this same committee with the request that a recommendation be reported at the next session.

The motion was seconded by Dr. Ellet of Berrien.

THE SPEAKER: It has been moved and seconded that this question again be referred to the same committee, with the recommendation that they report at the next session. Are there any remarks?

P. L. LEDWIDGE, M.D. (Wayne): Does Dr. Luce mean that we make recommendations to the House of Delegates as to what action shall be taken by the members of the A.M.A. or delegates?

DR. LUCE: Mr. Speaker, replying to the doctor's question, it is my personal feeling—I don't know about the other A.M.A. delegates—that in appearing before the House of Delegates of the A.M.A. we must say that the Michigan House of Delegates instructed us so-and-so, in order to have any emphasis back of it.

THE SPEAKER: All in favor of the motion say "aye"; opposed the same. The motion is carried. This will be referred to the Reference Committee to report at this evening's session.

L. J. HIRSCHMAN, M.D. (Wayne): I would like to raise a point of order. We have accepted the paragraphs on the reports of the various standing committees, but we have not accepted the report of the committee as a whole.

THE SPEAKER: You are perfectly right.

DR. HIRSCHMAN: I move, sir, that the report of the Reference Committee on Standing Committees be accepted as a whole, with the exception of the matters which have been referred back.

The motion was seconded by Dr. Gruber of Wayne, put to a vote and carried.

XI-4 ON SPECIAL COMMITTEE REPORTS

(Radio—IX-4)

THE SPEAKER: We will now have the Report of the Reference Committee on Special Committees.

A. V. WENGER, M.D.: This report embraces the reports of the Committee on Nurses' Training Schools, Conference Committee on Pre-Licensure Medical Education, Membership Committee, Radio Committee, Advisory Committee to Woman's Auxiliary, and Scientific Work Committee.

The Annual Report of the Radio Committee: Your Committee has read with approval the report of the Radio Committee and has noted its supplemental report as submitted to the House of Delegates this morning. Your Committee recommends respectful attention to the coördination with radio programs of other health and health education agencies.

Mr. Speaker, I move the acceptance of the report.

The motion was seconded by J. A. Kasper, M.D., of Wayne, put to a vote and carried.

XI-4. ON SPECIAL COMMITTEE REPORTS

(Advisory Committee to Woman's Auxiliary, IX-5)

DR. WENGER: The next is the Report of the Advisory Committee to Woman's Auxiliary. Your Committee has noted the report of the Advisory Committee and recommends that in the future the committee constitute itself a liaison committee to report annually to the House of Delegates concerning the year's work of the Woman's Auxiliary.

Mr. Speaker, I move that the report be accepted.

The motion was seconded by several, put to a vote and carried.

XI-4. ON SPECIAL COMMITTEE REPORTS

(Membership Committee, IX-3)

DR. WENGER: Annual Report of the Membership Committee: Your Committee notes with gratification that the present membership of 4,436 constitutes an all-time high. The remainder of the report of the Membership Committee is endorsed as it appears in the Handbook.

Mr. Speaker, I move that the report be accepted.

The motion was seconded by Charles S. Kennedy, M.D., of Wayne, put to a vote and carried.

XI-4. ON SPECIAL COMMITTEE REPORTS

(Nurses' Training Schools, IX-1)

DR. WENGER: Annual Report of Committee on Nurses' Training Schools: Your Committee notes the impassé confronting the small hospital which wants a nurses' training school. It sees no prospect of solution but recommends that the present committee be continued and instructed to keep in touch with the situation.

Mr. Speaker, I move that the report be accepted.

The motion was seconded by E. A. Oakes, M.D., of Manistee, put to a vote and carried.

XI-4. ON SPECIAL COMMITTEE REPORTS

(Scientific Work, IX-6)

DR. WENGER: On the Report of the Scientific Work Committee: Your Committee congratulates the officers

and the Scientific Work Committee on the arrangement and scope of the scientific program which begins tomorrow morning. We bespeak the attendance and interest that its merit deserves.

Mr. Speaker, I move that the report be accepted. The motion was seconded by Dr. Kasper of Wayne, put to a vote and carried.

XI-4. ON SPECIAL COMMITTEE REPORTS

(Prelicensure Medical Education, IX-2)

DR. WENGER: On the Report of the Conference Committee on Prelicensure Medical Education, your Committee has read with approval the pioneer work of this Committee and recommends its continuation.

Mr. Speaker, I move the report be accepted. The motion was seconded, put to a vote and carried.

DR. WENGER: Mr. Speaker, I move that the report be accepted as a whole.

The motion was seconded by Dr. Snapp of Kent, put to a vote and carried.

THE SPEAKER: The next order of business is the Report of the Reference Committee on Amendments to the Constitution and By-Laws.

XI-5. ON AMENDMENTS TO CONSTITUTION AND BY-LAWS

(Re Finances, VII-1)

C. F. DEVRIES, M.D.: The first proposed amendment to the Constitution was submitted by Paul W. Kniskern, M.D., of Kent County, to change Article IX, Section 4, to read:

"The Secretary shall collect all annual dues and all monies owing to the Society, depositing them in an approved depository and disbursed by him upon order of The Council, or invested by him in United States Government bonds with approval of The Council.

The Committee feels that this proposed amendment is unnecessary. The argument seems to be upon the interpretation of the word "disbursed." It is the consensus of the Committee that disbursed also means invested. We, therefore, recommend that this proposed amendment be rejected.

THE SPEAKER: Is there a support to that?

DR. ELLET (Berrien): I support it.

THE SPEAKER: You have heard the motion and the recommendation, and it is supported. Is there any remark?

The motion was put to a vote and carried.

DR. DEVRIES: The next proposal:

XI-5. ON AMENDMENTS TO CONSTITUTION AND BY-LAWS

(Re Past President, VII-2)

"BE IT HEREBY RESOLVED, That Article IV, Sections 1 and 2 of the Constitution be amended to provide for the retention of Past Presidents as Delegates at Large with power to vote."

There is a note that the wording of the amendment is to be determined by the Committee on Amendments to the Constitution.

We studied Sections 1 and 2, and we would like to recommend that they be left as they are, and that Section 3 be changed to read as follows: "The Officers of this Society, Past President, and Members of the Council shall," and so forth, and so forth.

In other words, we are adding the words in Section 3, "Past Presidents." We feel that that would cover the purpose of this proposed change.

I move the acceptance of this report.

The motion was seconded by C. F. Brunk, M.D., of Wayne.

HENRY LUCE, M.D., (Wayne): Do I understand then the House of Delegates would be constituted of the legally elected delegates, the members of the Council, and officers of the Society, and the Past Presidents? Is that the interpretation?

THE SPEAKER: I will ask Dr. DeVries to give the explanation.

DR. DEVRIES: No, this article, as we proposed it, would read as follows: "The officers of this Society, Past Presidents, and members of the Council shall be ex-officio members of the House of Delegates, without power to vote."

THE SPEAKER: You have heard the motion, made and supported. Are there any more remarks? If not, all in favor say "aye."

DR. REEDER: I just don't see the necessity of this. The members of the Council and the Past Presidents have always been welcome in this House of Delegates. What is the need of it? What have you added in giving the Past Presidents permission to attend but no power to vote? They have always been welcome without power to vote. Naturally, they should be. I don't see what you have gained.

C. K. HASLEY, M.D. (Wayne): We have in our presence Dr. Luce, just to give an example, who is one of our Past Presidents. He was duly elected as a delegate by the Wayne County Society. If such an amendment to the Constitution were adopted, he would not have power to vote. I don't see the necessity for that amendment.

W. C. ELLET, M.D. (Berrien): Mr. Speaker, I might explain that. That will not prevent Dr. Luce from being a duly elected delegate from Wayne County. But Wayne County has five or six Past Presidents. If each Past President were allowed to vote, that would increase the delegation of Wayne County to that many men.

I think Dr. DeVries can explain to you the reason for that amendment in the first place; that is, in regard to why the Past Presidents wanted to feel free to come in here.

THE SPEAKER: Dr. DeVries, do you wish to say anything further?

DR. DEVRIES: I think Dr. Ellet has explained it. They are not mentioned in the present provision, and whoever submitted the proposal I think wanted to have them officially recognized to be here as visitors.

These are proposed amendments to the Constitution and have to be tabled for one year.

DR. GRUBER: If I am able to understand the English language, the officers of this Society, Past Presidents and members of The Council shall be ex-officio members of the House of Delegates without power to vote. There are several Past Presidents here—Dr. Robb, Dr. Penberthy, Dr. Luce—and they would not have the power to vote even if they were elected delegates. I think it would be a very improper thing to even give any person a chance to argue about it.

DR. LUCE: Do I understand, as a point of order, that this is a change in the Constitution?

THE SPEAKER: It is, Doctor.

DR. LUCE: Then it is my understanding, Mr. Speaker, that all that is necessary for you to do is lay it on the table for another year, because it cannot be acted on.

THE SPEAKER: You are perfectly right. However, I thought it was put through the regular machinery of acceptance and adoption and then laid on the table. If it is merely laid on the table after reading by the Chairman of the Reference Committee, I am in error. It was my impression that it first had to be voted on.

THE SPEAKER: It will be referred to the Reference Committee of 1941.

XII. Unfinished Business

XII-1. RE MEMBERSHIP CLASSIFICATION AMENDMENTS TO CONSTITUTION ARTICLE III—SECS. 1, 2, 3, 4, 8

DR. DEVRIES: There are several proposals to change the Constitution of the Michigan State Medical Society presented at the 1939 session of the House of Delegates.

Article III, Section 1, amend to read as follows:

"This Society shall consist of active members, honorary members, associate members, retired members, and members emeritus."

I move the adoption of this proposed change. Motion was seconded and carried.

DR. DEVRIES: To continue with Section 2, the proposed amendent reads as follows:

"*Active Members.*—Active members shall comprise all the active members of component county societies. To be eligible for active membership in any component county society, every person must be under license to practice medicine and surgery and midwifery by authority of the Michigan State Board of Registration in Medicine."

I move the adoption of this proposed amendment.

The motion was seconded by Dr. Hirschman of Wayne, put to a vote and carried.

DR. DEVRIES: Article III, Section 3, to be amended as follows:

"*Honorary Members.*—County Societies may elect as Honorary Members any persons distinguished for their services or attainments in medicine or the allied sciences, or other services of unusual value to organized medicine or the medical profession. Upon recommendation of a County Society, the House of Delegates may elect such persons as Honorary Members of the State Society.

"Honorary members shall not pay dues and shall not have the right to vote or hold office in any County Society or the State Society."

I move the adoption of this proposed amendment.

The motion was seconded by Dr. Reveno of Wayne, put to a vote and carried.

DR. DEVRIES: Article III, Section 4, amend to read as follows:

"*Associate Members.*—County Societies may elect as Associate Members:

"1. Persons not members of the profession but engaged in scientific or professional pursuits whose principles and ethics are consonant with those of this Society.

"2. Internes serving their first year in any approved hospital, internes of longer standing, resident physicians in training, and teaching fellows not engaged in private practice, but not after five years from the receipt of first medical degree (M.D. or M.B.).

"3. Commissioned medical officers of the United States Army, Navy, Public Health Service and Veterans' Administration on duty in this state who are not engaged in private practice of medicine.

"4. Physicians not engaging in any phase of medical practice.

"Upon recommendation of a County Society, the House of Delegates may elect such persons as Associate Members of the State Society. Associate Members shall not pay dues in the State Society, nor shall they have the right to vote or hold office in either County or State Society.

"County Societies may require Associate Members to pay certain local dues, out of which THE JOURNAL subscription is to be paid to the State Society and for which such Associate Members shall receive THE JOURNAL."

I move the adoption of the proposed amendment.

The motion was seconded by Frank Reeder, M.D., of Genesee.

DR. GRUBER: This amendment penalizes the man who graduates from a medical school outside of the state, maybe even from Ann Arbor. For instance, the University of Detroit does not give the degree of M.B. or M.D. until after the interne has served one year. I don't know what the arrangement is in Michigan, but I believe they get their M.D. at the time they graduate. In other institutions, outside of the state, they receive their M.D. or M.B. at the time they graduate. So the men who are graduating from schools where they get their M.D. at the time of graduation are penalized one year, in reference to those who would have longer. Those men would have five years, and the other men would have six years after graduating from medical school.

J. A. KASPER, M.D. (Wayne): Unless the situation has changed recently, Wayne University also grants a degree of M.D. before the internship year is completed.

The question was called for, the motion put to a vote and carried.

DR. DEVRIES: Article III. It is proposed to add a new section as follows:

"Section 7. *Non-Resident Members.*—County Societies may elect and retain as Non-Resident Members, physicians residing and practicing outside of the County who are members in good standing of their own County Medical Society. Non-Resident Members shall not have the right to vote or hold office."

I move the adoption of this addition to Article III. (Subsequently this was reconsidered—see page 879—and Section 7 was renumbered Section 8.)

The motion was seconded, put to a vote and carried.

XII-2. AMENDMENT TO CONSTITUTION RE MEMBERSHIP OF THE SOCIETY OFFICERS IN THE HOUSE OF DELEGATES ARTICLE IV—SEC. 3

DR. DEVRIES: Article IV, Section 3. Amend to read as follows:

"The officers of this Society and the members of The Council shall be ex-officio members of the House of Delegates, and, with the exception of the Speaker of the House of Delegates, shall be without power to vote in the House of Delegates."

I move the adoption of this amendment.

The motion was seconded by Dr. D. Bruce Wiley of Macomb, put to a vote and carried.

DR. ELLET: I rise on a point of order. I want the House polled, because to adopt an amendment to the Constitution requires a two-thirds vote. I call your attention to Article XII.

THE SPEAKER: You are right. The Chair was judging from the sound of the voices.

DR. ELLET: Mr. Speaker, I want the total number of delegates in the House now. I doubt there are two-thirds of the members present.

THE SPEAKER: All right. Sergeant-at-arms, will you poll the delegates?

DR. ELLET: I ask the Secretary to call the roll, Sir.

THE SPEAKER: Will the Chairman of the Credentials Committee make a judge as to the number of delegates present and whether or not there is a quorum.

DR. ELLET: Mr. Speaker, what is the total number of registrations for this afternoon's session?

THE SPEAKER: What were the total number of registrations for this afternoon?

DR. FOSS: I think there were about eighty-four.

THE SPEAKER: How many are present now?

DR. FOSS: Fifty-two, and 40 per cent constitutes a quorum.

THE SPEAKER: A quorum is present.

Now, what is your wish, Dr. Ellet?

DR. ELLET: I am still voting "no," Sir, leaving the Chair to rule.

THE SPEAKER: The Chair is ruling by the vociferousness of the various delegates, and so far has ruled that it has been a two-thirds majority.

The last amendment was carried.

XII-3. AMENDMENT TO CONSTITUTION RE JUNIOR MEMBERSHIP, ARTICLE III—SECS. 1, 2

DR. DEVRIES: Proposed amendment to the Michigan State Medical Society Constitution, Article III, Section 1, line 2, after the first word "members," by inserting the words "junior members."

I move the adoption of that amendment.

The motion was seconded by Dr. Kasper of Wayne, put to a vote and carried.

DR. DEVRIES: To amend the Constitution, Article III, Section 2, by inserting a new section to be known as Section 3, to read as follows:

"*Junior Members.*—Physicians who are Internes (or Residents) in recognized hospitals of Michigan and who hold the degree of Doctor of Medicine, or who upon completion of their internship will be awarded such degree, issued to them by an institution of learning accredited by the American Medical Association are eligible for Junior Membership. They shall be entitled to receive the publication of the Society at such rates as The Council may, from time to time, determine. They shall not have the right to vote or hold office. With the approval of The Council, such a Junior Member, who shall have been awarded the degree of Doctor of Medicine, may be continued as a Junior Member for a reasonable period after completion of his hospital work, to permit him sufficient time to comply with the eligibility requirements of his county society."

I move the adoption of that addition.

The motion was seconded.

The motion was put to a vote and carried.

XII-4. AMENDMENT TO CONSTITUTION RE RENUMBERING OF SECTIONS, ARTICLE III—SECS. 3, 4, 5, 6 TO SECS. 4, 5, 6, 7

DR. DEVRIES: Amend the M.S.M.S. Constitution, Article III, by renumbering old Sections 3, 4, 5, and 6 to read 4, 5, 6, and 7, respectively.

I move the adoption of that.

XII-5. RECONSIDERATION OF NUMBERING NEW SECTION 7 OF ARTICLE III (See Page 878) TO SECTION 8

DR. GRUBER: A point of information. Didn't they add a new Section 7 a little while ago?

THE SPEAKER: It has been mentioned there.

DR. GRUBER: Then you would have No. 8 instead of No. 7, for the section you mentioned a little while ago.

DR. DEVRIES: That is right. That will be corrected.

DR. GRUBER: Mr. Speaker, is it in order to reconsider the action on the former Article III, Section 7?

THE SPEAKER: Yes.

DR. GRUBER: I move that we reconsider our action on the adoption of the additional section, No. 7, on Non-Resident Members.

The motion was seconded by Dr. Oakes, put to a vote and carried.

DR. GRUBER: Mr. Speaker, I believe it would be the duty of the Chairman to reread the recommendation.

Dr. DeVries reread the proposed amendment on Non-Resident Members.

DR. GRUBER: You said, Section 7 be added. Now instead of saying 7, you can say that Section 8 should be added.

DR. DEVRIES: This would be Article III, Section 8. I move the adoption.

The motion was seconded by Dr. Snapp of Kent, put to a vote and carried.

DR. DEVRIES: I move the acceptance and adoption of the report as a whole.

The motion was seconded by Dr. Simpson of Wayne.

THE SPEAKER: We do not have a sufficient number of delegates present to vote upon this question.

We will have to waive the consideration of it until we get a quorum or two-thirds of the members registered at that session. If necessary, we will have to wait until tonight.

DR. HIRSCHMAN: I move that the report be deferred until this evening, and then we can vote on the report as a whole. The motion was seconded and carried.

DR. REEDER: Mr. Speaker, I move that we recess until eight-fifteen this evening.

The motion was seconded by Dr. Hirschman, put to a vote and carried, and the meeting recessed at six-ten o'clock.

Tuesday Evening Session

September 24, 1940

The meeting was called to order at eighty thirty-five o'clock, Dr. Stryker, the Speaker, presiding.

THE SPEAKER: This is a recess session of the Second Session of the House of Delegates.

At this time, I would like to call on a friend and an honored guest, who is with us tonight. We will set aside the usual order of business to listen to Mr. Dwight Anderson, Director of the Public Relations Bureau of the Medical Society of New York, who will speak to us for a while at this time. Mr. Anderson.

ADDRESS OF DWIGHT ANDERSON

MR. DWIGHT ANDERSON: Mr. Speaker and Members of the House of Delegates of the Michigan State Medical Society: I bring you greetings from the Medical Society of the State of New York.

As I stand here before your microphone, I am reminded of Dr. Holman Taylor's remark once in addressing the House of Delegates of the A.M.A., when he said that a microphone isn't worth a damn if you don't hit it. (*Laughter*)

I feel that I am taking back to New York a great deal more than I can possibly bring here. I appreciate coming out here. Your group, being so homogeneous, it seems to me, presents a typical picture of medicine at its best. I feel that your progressive qualities are something that we can very well emulate.

For example, the first letter I received from Dr. Foster explained in full what he would like to have me do, when to be here, precisely what the accommodations and arrangements would be. Subsequently, I received two or three letters from Mr. Burns, and someone was appointed to meet me at the train, take care of me, bring me to the hotel and show me around. That is something we do not do. I think that in New York it must be a very uncomfortable experience for strangers invited to come to our meetings as our guests to have to find their way around.

As a matter of fact, I remember an instance when I first came with the Medical Society of the State of New York, where that was illustrated. At that time, I was starting new, and I had not fully acquainted myself with some of the speakers on the program. One of them was a very eminent anatomist from Cleveland, Dr. T. Wingate Todd. There was nothing in his paper I remember; it had been passed by the committee as having nothing of news value, so it slid out of my recollection. Many of you will remember Dr. Todd, who, unfortunately, passed away about a year or so ago.

Dr. Todd came into the Press Room one morning. He was a rather angry Scotchman. I don't blame him. He had walked up from the station and was trying to find out where he was supposed to go. He came into the Press Room and said, "I am T. Wingate Todd."

I said, "How do you do, Mr. Todd?" I was in rather bad shape right then.

Then he said, "I am from Western Reserve University."

I said, "A very good school. I went there myself." (*Laughter*)

Things became rapidly worse, until finally I tumbled to the fact; my secretary, I think, tipped me off. So I stopped work immediately and took Dr. Todd up to the University Club, where there was a session of the medical men who were getting ready for the meeting, and we saw that he was properly taken care of.

I am going back to New York, and I am going to take this knowledge with me, and I feel we will certainly want to do as you are doing next year.

Then the Office Secretaries' Meeting this noon was an illuminating example of what can be done in establishing public relations by increasing the efficiency of the office secretaries.

Another thing that I wanted to learn—and I was particularly asked to inquire—is why it is that everywhere our salesmen who sell exhibit space at our meeting go they are quoting the Michigan State Medical Society. The exhibitors all want to know why the New York State Medical Society does not have the men out to observe the exhibits and have them so arranged that they will be more accessible. So I am taking that back, too.

I am going to talk for only a few minutes. I have only one or two things I would like to say.

When we started our Bureau, it was a moot point whether or not we should call it a Public Relations Bureau and Information Service, or camouflage it and call it by some other name, a secretaryship or something of that kind. We went pretty thoroughly into that, and decided—and it has been proved to be the case—that it is wiser for us to establish a Public Relations Bureau and call it a Public Relations Bureau. We felt that our releases going out to newspapers would be accepted as being correct and accurate when the responsibility of their authorship was traceable definitely to a representative group in the community.

In the six years that we have been in existence we have not had an instance where a slighting or disparaging statement has been made by any journalist or anyone else connected with the avenues of communication, criticizing us for having our Bureau. We started out to try to establish with the press and with others a reputation for truth and accuracy, feeling that in a day when the opportunities for the dissemination of information were so clogged by our modern civilization the profession did well to do so, and had a perfectly good right to establish a function of interpretation.

We have also had the problem of taxation come up. Some of us have been a little concerned as to whether or not such activities subjected us to income tax. We have had that passed on by men in Washington, private counsellors, and men in New York who have gone thoroughly into the law, and have established to our satisfaction that a Public Relations Bureau, such as we have conducted, does not render the organization subject to income tax.

So far as our success is concerned, it was indicated to me that perhaps I might say something about that. All I can say, inasmuch as I have been doing the work for the Committee and under the guidance of our Council, is that at first it was felt that we were doing a pioneering and a new thing. Many thought it would not last. From many standpoints, it seemed to violate the traditional principles of the profession, but we drew quite a line between individual personal aggrandizement and the reputation of the group, and we hewed pretty carefully to the policy of permitting the men to be quoted who were most nearly concerned with the subject matter. The officers of the Society, when it properly would fall within the functions of their office to make a statement, were the ones to make it. In other examples, we had chairmen of committees and various other individuals. We have yet to be criticized for the selection of any individual who has spoken.

In fact, some of the things that it was thought would get us into trouble have not gotten us into trouble at all. It has been very interesting to watch the development. We will begin next January our seventh year, and we feel that we are better understood. We feel that the money we spend is by way of insurance. We feel that the fact that we have the machinery for molding public opinion and for interpreting the medical profession's ideas and principles to the public acts as a deterrent against certain encroachments which formerly were made by certain groups who do not see eye to eye with the medical profession. They are intangibles. They cannot be measured. The imponderables are sensed rather than computed.

We have continued to renew our Public Relations Bureau at each meeting of the House of Delegates. Reference committees have gone over our work. On the whole, I think we can say now that we have definitely passed the time when it can be said to be an experiment, and we can say that wholeheartedly today the medical profession in the State of New York feels that it is worth while to have the Public Relations Bureau.

I thank you for this opportunity to speak before you. I feel honored to be given a chance to say these few words to you now. Thank you. (*Applause*)

THE SPEAKER: Thank you, Mr. Anderson.

* * *

We are now continuing the afternoon session, which was recessed until this evening.

We were considering the reports of reference committees, and it reached the stage of the report of the Reference Committee on Amendments to the Constitution and By-Laws. The question of amendments to the Constitution and By-Laws had been discussed, and a motion had been made by the Chairman of the Committee that the report of the Committee on Amendments to the Constitution and By-Laws be accepted as a whole.

No vote having been taken upon this question, I will at this time call for discussion.

THE SPEAKER: The question has been called for. Those of you who are in favor of the motion will say "aye"; those opposed will signify by the same sign. The motion is carried.

H. F. DIBBLE, M.D. (Wayne): I would like to move that we revert back to new business again, which we left this afternoon.

The motion was seconded by A. E. Catherwood, M.D., of Wayne, put to a vote and carried.

X-4. PROPOSED AMENDMENT TO CONSTITUTION RE SESSIONS AND MEETINGS TO BE NEW ARTICLE XII; AND TO RENUMBER PRESENT ART. XII —AMENDMENTS TO ART. XIII

THE SPEAKER: We are now on New Business.

T. K. GRUBER, M.D. (Wayne): Following the angle of this afternoon, I have a proposed amendment to submit. If it doesn't clarify the situation, I can change it so it does clarify the situation.

Amend the present Article 12, Section 1, line 3, second word, by substituting the word "seated" for the word "present."

Amend the Constitution by adding a new article, which shall be Article 12:

SESSIONS AND MEETINGS.

"Section 1. A session shall mean all meetings at any one call.

"Section 2. A meeting shall mean each separate convention at any one session."

Amend Article 12 by renumering to Article 13.

X-5. PROPOSED AMENDMENT TO BY-LAWS RE "AMENDMENTS" CHAP. 10, SEC. 1

Now, if you will turn to the last page, under Amendments to the By-Laws, Chapter 10, Section 1, line 3, last word, amend by substituting the word "meeting" for the word "session."

Mr. Speaker, I move that the amendment to the By-Laws be laid on the table until the 1941 session.

THE SPEAKER: Is there a second to that motion? The motion was seconded.

THE SPEAKER: It is moved and seconded that the amendment to the By-Laws as presented now be laid on the table until the 1941 session. Are there any re-

marks? If not, all in favor say "aye"; contrary the same sign. It is carried.

The amendments to the Constitution will automatically go to the next year's session and be referred to the Committee on Amendments to the Constitution and By-Laws at that time.

VI-3. SPECIAL MEMBERSHIP

LUTHER W. DAY, M.D. (Hillsdale): May I present this resolution now?

Dr. Day read a resolution asking that the late Stewart W. Pritchard, M.D., be elected to Honorary Membership.

THE SPEAKER: The resolution of Dr. Day will be referred to the Reference Committee on Resolutions.

At this time we will revert to the order of business. I will entertain a motion to revert to the usual order of business.

Upon motion regularly made and seconded, the meeting reverted to the usual order of business.

THE SPEAKER: I will now call on Dean W. Myers, M.D., Chairman of the Committee on Resolutions.

XI-6. ON RESOLUTIONS (Special Memberships, VI-3)

DEAN C. MYERS, M.D.: Your Reference Committee on Resolutions begs to report as follows:

There were several resolutions offered with reference to the election of members to special memberships. In accordance with the resolutions offered, your Committee on Resolutions recommends the election of the following members, who have fulfilled the constitutional requirements and have been so certified by the officers of the Michigan State Medical Society, to special membership as follows:

To Emeritus Membership—

W. J. O'Reilley, M.D., Saginaw
Donald K. MacQueen, M.D., Laurium
George Bates, M.D., Kingston
Leslie A. Howe, M.D., Breckenridge
James H. Sanderson, M.D., Detroit
Frank B. Bohn, M.D., Newberry

To Retired Membership—

C. S. Sackett, M.D., Charlotte
E. M. Cooper, M.D., Rockwood
Mark S. Knapp, M.D., Lake Fenton
C. S. Sutherland, M.D., Clarkston
James W. Wallace, M.D., Saline
James F. Breakey, M.D., Ann Arbor
W. E. Wilson, M.D., Kent County
T. W. Hammond, M.D., Kent County

To Associate Membership—

Mr. John R. Mannix, Detroit.

I move that this part of our report be adopted.

T. T. HOFFMAN, M.D. (Tuscola): I second the motion.

THE SPEAKER: You have heard the recommendation, which has been moved and supported. Is there any discussion?

THE SPEAKER: All in favor please say "aye"; opposed, by the same sign. That is carried.

XI-6. ON RESOLUTIONS (Speaker's Gavel, VI-2)

DR. MYERS: A resolution offered by Dr. Gruber with reference to the retirement of the old Speaker's gavel and the presentation of a new one.

WHEREAS, The gavel used by Speakers of this House of Delegates for many years now has so many names inscribed on it there is scarcely room for another, and

WHEREAS, This old gavel has acquired historic and sentimental value, and

WHEREAS, The Wayne County Medical Society offers to house and display this gavel properly in the society headquarters so long as The Council of the State Society may choose to leave it there; and

WHEREAS, The Wayne Delegation begs leave to present to the House of Delegates, for use by the Speaker, a new gavel and percussion piece made by a member of this Society from oak grown on Mackinac Island, the scene of William Beaumont's great work, therefore be it

RESOLVED, That this House of Delegates retire the old gavel from use, accept the Wayne County Medical Society's offer of housing and display, and permit the Wayne Delegation to present the Speaker with this new gavel.

We recommend the adoption of this resolution.

The motion was seconded by R. M. McKean, M.D., of Wayne, put to a vote and carried.

THE SPEAKER: At this time, when I look at this gavel and see the names of some of the men who handled it, I only hope their successors with the new gavel will do one tenth as well as these men have done.

XI-6. GENERAL PRACTITIONERS IN HOSPITAL (VI-9)

DR. MYERS: The resolution offered by Dr. McClellan, with reference to the consideration of general practitioners, their relationship and opportunities in Class A Hospitals:

WHEREAS, The Board of Trustees of the American Medical Association and the Board of Regents of the American College of Surgeons met in conference at the headquarters office of the American Medical Association on November 16, 1939. Consideration was given to many questions concerned with the appointment of the staffs of hospitals and the manner in which the two organizations could function together in the maintenance of the quality of medical service in our country.

WHEREAS, Since then there has been a purge of hospital staffs which has been a hardship to general practitioners,

WHEREAS, General practitioners are being denied hospital privileges which they have had for years,

WHEREAS, All general practitioners should not be judged as giving poor quality work, because there are occasionally poor practitioners,

WHEREAS, Most general practitioners are anxious to do quality work,

WHEREAS, Many practitioners do and have done excellent work which is above reproach,

WHEREAS, Many minor procedures which have been done well by general practitioners are now called major procedures to be done only by specialists,

WHEREAS, Many doctors have had postgraduate training but are denied recognition because they have not specialized,

WHEREAS, It is unjust to force a general practitioner to refer cases to a specialist when he is capable of taking care of the case himself, therefore, be it

RESOLVED, By the Delegates of the Michigan State Medical Society in session September 24, 1940, that the Board of Trustees of the American Medical Association be requested to urge more just and liberal consideration of hospital privileges for general practitioners in Class A Hospitals.

As to this resolution, the Committee recommends that a study of this recommendation be made by the Committee on Distribution of Medical Care of the Michigan State Medical Society, to be referred to the Executive Committee for action or to be returned to the House of Delegates.

I move the adoption of this report.

The motion was seconded by E. N. D'Alcorn, M.D., of Muskegon, put to a vote and carried.

XI-6. AMENDMENT TO AFFLICTED CHILDREN'S ACT (VI-5)

DR. MYERS: Resolution offered by Dr. Callery, regarding Crippled and Afflicted Children's Acts.

To the Delegates of the Michigan State Medical Society:

WHEREAS, Under the present Crippled and Afflicted Children's Acts, an attempt has been made to take the jurisdiction out of the Probate Court, and great confusion and suffering has resulted therefrom, and

WHEREAS, The allocations made to the individual counties have been made according to the population and should be made according to the needs of the individual counties, and

WHEREAS, The Probate Judges are more familiar with the situation and the needs of the individual cases and can work for better advantage for said children, through the coöperation of the local physicians, and

WHEREAS, Local physicians today are called upon to furnish a great amount of free care, under the present system, or many cases would be neglected, therefore, be it

RESOLVED, That the Michigan State Medical Society recommend that the Legislative Committee endeavor to have the present Afflicted Children's Act so amended that the medical and surgical care of indigent children be removed from the jurisdiction of the Michigan Crippled Children Commission, and that the jurisdiction over all such children's care be returned to the Probate Judges of the respective counties of the state, who, under the Constitution of this State, have the exclusive care and control of indigent children.

St. Clair County Medical Society,
A. L. CALLERY, M.D., Delegate.

We recommend that this resolution be referred to the Legislative Committee of the Michigan State Medical Society.

THE SPEAKER: Is there a second to that?

The motion was seconded by Dr. Novy of Wayne, put to a vote and carried.

XI-6. CHANGE OF COUNTY SOCIETY NAME (VI-4)

DR. MYERS: The resolution offered by Dr. Keyport, with reference to the amalgamation of the O.M.C.O. R.O. and Kalkaska and Gladwin Counties was studied. We recommend the adoption of the resolution reamalgamating the counties of Otsego, Montmorency, Crawford, Oscoda, Roscommon, Ogemaw, Kalaska and Gladwin Counties, to be named "The Medical Society of the North Central Counties."

The resolution offered was as follows:

WHEREAS, The majority of the physicians of Kalkaska County and of Gladwin County (contiguous to the territory of the O.M.C.O.R.O. County Medical Society) are members of the O.M.C.O.R.O. Medical Society; and

WHEREAS, These physicians of Kalkaska and of Gladwin Counties feel that greater good can be accomplished by their counties becoming part of the O.M.C.O.R.O. Society; and

WHEREAS, The members of the O.M.C.O.R.O. County Medical Society favor the amalgamation of Kalkaska County and of Gladwin County and the present counties comprising the O.M.C.O.R.O. Medical Society; therefore be it

RESOLVED, That the O.M.C.O.R.O. County Medical Society members, together with the physician members of Kalkaska and of Gladwin Counties, respectfully, petition the House of Delegates of the Michigan State Medical Society to amalgamate Kalkaska and Gladwin Counties with the O.M.C.O.R.O. group (Otsego, Montmorency, Crawford, Oscoda, Roscommon, and Ogemaw), and further that the name of the O.M.C.O.R.O. County Medical Society be changed to "North Central Medical Society," to include Otsego, Montmorency, Kalkaska, Crawford, Oscoda, Roscommon, Ogemaw, and Gladwin counties.

C. G. CLIPPERT, M.D.,
Secretary, O.M.C.O.R.O. Medical Society.

There is just a slight modification. The name suggested by the O.M.C.O.R.O. Society for the new society was North Central Medical Society, and we changed the wording just a little bit and recommend that the Society be called Medical Society of the North Central Counties.

I move the adoption of the recommendation.

The motion was seconded by Dr. Kasper of Wayne, put to a vote and carried.

XI-6. MATERNAL HEALTH (VI-7)

DR. MYERS: Resolution offered by Dr. Ekelund, with reference to maternal health.

WHEREAS, public health agencies, supported by taxpayers, exist to provide "Preventive Medicine" to large portions of our population; and,

WHEREAS, Birth control, which makes family planning and child spacing possible, can lower infant and maternal mortality and morbidity, decrease the number of abortions, aid in the prevention of congenital diseases, and promote a higher standard of health for the family and community, be it

RESOLVED, That the Michigan Medical Society urges the inclusion of birth control service in national, state and local health and welfare programs and endorses efforts directed toward this objective.

Respectfully submitted,
CLIFFORD T. EKELUND, M.D.,
Delegate,
Oakland County Medical Society.

We recommend to the House of Delegates that this resolution be not adopted at this time because of the highly controversial nature of the subject.

I move the adoption of the recommendation of the Committee.

The motion was seconded by Dr. Ekelund.

R. S. BREAKEY, M.D. (Ingham): Since this has already been endorsed by the Section on Gynecology and Obstetrics of the American Medical Association, since it has been endorsed in full by other national medical societies, I merely rise to ask a question—Are we moral cowards or not?

R. L. NOVY, M.D. (Wayne): We don't have to follow them.

DR. BREAKEY: No, but we do have patients coming to us, seeking help and advice, and there is the question of three million abortions a year, with an instance in one of our local hospitals of 267 admissions in one year with puerperal septicemia with five deaths. That is something that should conjure the wisdom of this body.

I was not on that committee. I was very pleased to hear the doctor present that resolution. I am not opposing the wisdom of Dr. Myers' committee, and I greatly respect him, but I hope these remarks go on the minutes and that the matter may be considered next year by this House.

THE SPEAKER: Any more remarks?

If not, all in favor say "aye"; opposed. The motion is carried.

XI-6. BEAUMONT BRIDGE (VI-8)

DR. MYERS: We recommend the adoption of the resolution naming the new bridge connecting Mackinac City with St. Ignace after Dr. Beaumont.

The resolution is as follows:

WHEREAS, Plans are in progress for the construction of a bridge from Mackinac City to St. Ignace, connecting the two beautiful peninsulas which constitute the State of Michigan, and

WHEREAS, The area in the vicinity of this great public project is sanctified by the research work and scientific contribution of an Army doctor, William Beaumont, Doctor of Medicine, who, in 1833 at Fort Mackinac, with keen scientific insight and true medical interest, made the first publication of physiology of digestion. This work, done under tremendous difficulties, was the most important on this subject to that date and laid much of the foundation for future studies. His studies were begun at an isolated military post in the wilderness of Northern Michigan and completed only by following up his patient and bringing him nearly two thousand miles to Plattsburg, New York. This is one of the great dramatic episodes in the history of medicine, and

WHEREAS, The contributions of Doctor Beaumont to the science of medicine have saved untold lives and relieved the distress and pain of thousands of our fellow beings, therefore, be it

RESOLVED, That the proper authorities be petitioned by the Michigan State Medical Society to christen this bridge structure in honor of William Beaumont, M.D., as a method of publicly recognizing this great physician for his contribution to the relief of human suffering.

I move the adoption of the recommendation.

The motion was seconded by Dr. Breakey, put to a vote and carried.

DR. MYERS: I move the adoption of the report as a whole.

The motion was seconded by Dr. Gruber of Wayne, put to a vote and carried.

HENRY A. LUCE, M.D., (Wayne): Mr. Speaker, at this point, I should like to move the suspension of the regular order of business to return for a few moments to New Business.

The motion was seconded by Dr. Gruber, put to a vote and carried.

THE SPEAKER: We are now under the order of New Business.

X-6. PRESENTATION OF NEW GAVEL (VI-2)

DR. LUCE: Mr. Speaker, in view of the adoption of the resolution and the favorable action on it, it is no more than proper and correct at this time to carry out that portion of the designated program.

Mr. Speaker, before presenting this gavel, let me congratulate you on being the first speaker to have your name inscribed on this silver plate. As this Speaker just said, almost sacred and hallowed memories are about this former gavel that was used.

To those who are not already familiar with its history, it was presented to the Society by Dr. Hornbach at the Marquette Meeting and is solid copper.

Returning to the topic of the new gavel, in 1825, Dr. William Beaumont, then a young surgeon in the

United States Army, located on Mackinac Island, began his studies of the digestion, which he pursued with great labor and skill for the benefit of mankind. It was by the greatest of good fortune that such a rare condition as an accidental gastric fistula fell into the hands of so remarkable a man as Dr. Beaumont. His famous publication appeared in 1833. Beaumont's work was the most important on the physiology of gastric digestion before the time of Pavlov, and was done under tremendous difficulties. His studies were begun at an isolated military post in the wilderness of North Michigan, and completed only by following his patient and bringing him nearly two thousand miles to Plattsburg, New York. This is one of the great, dramatic episodes in the history of medicine.

The old oak lumber used in making this gavel and sounding board was secured for us by Carl S. Cook, M.D., who lives on Mackinac Island. This tree no doubt was growing on Mackinac Island at the time Beaumont started his great work there.

The gavel and sounding board and case were made by a Detroit surgeon, who does expert cabinet work, and who modestly declines to have his name mentioned in this connection. It is a most remarkable thing that a Detroit surgeon does not like to brag about his carving. (*Laughter*)

This gavel is not made in elaborate, ornamental form, nor is it engraved or carved in any way, but is well made, of sound oak. Although its intrinsic value is not high, this gavel has a historic and sentimental value, which will increase with passing years, as it is used by a succession of speakers.

This gavel is a symbol of democracy. In the idiom of 1940, it is a device to implement democratic government in this Society. The Wayne Delegation presents it, with the sincere hope that it will never need to be used to quell dissension in this honorable body, with the hope that it will long and successfully uphold the Speaker's authority and facilitate performance of the important work for which the Michigan State Medical Society has become known throughout this country.

With this, Mr. Speaker, may I be permitted to sound the first note on the gavel. (Tapping the gavel) (*Applause*)

THE SPEAKER: A silver plate on the box reads as follows:

"Speaker's Gavel, presented to the House of Delegates, Michigan State Medical Society, by the Wayne County Delegation at the meeting in Detroit, September 24, 1940."

Dr. Luce, as Speaker, I feel very proud that I am allowed to accept this gavel in the name of the House of Delegates of the Michigan Medical Society. (*Applause*)

R. L. NOVY, M.D. (Wayne): Mr. Speaker, May I ask that when Dr. Luce's speech is published, it be torn out of THE JOURNAL and pasted on the inside of the box, so that when this box in turn goes among the archives, those who are there can read it. (*Applause*)

THE SPEAKER: At this time, we also take pleasure, without any permission from the House, in turning over the old gavel to the Wayne County Medical Society. I understand it is to have an honored place in the home of the Wayne County Society. Will the President of the Wayne County Medical Society come and accept this gavel?

ALLAN MCDONALD, M.D. (Wayne): I would be very proud to do so.

The old gavel was presented to Dr. McDonald.

THE SPEAKER: This completes the order of business for the second session. The Speaker will now declare a recess for ten minutes, after which the evening session, or the third session, will start.

The meeting recessed at nine-twenty o'clock.

The Third Session of the House of Delegates convened at nine-thirty o'clock, The Speaker presiding.

THE SPEAKER: I will now declare the Third Session of the House of Delegates in order.

May we have the supplementary report of the Committee on Credentials?

DR. FOSS: There are ninety delegates present at the current session, which constitutes a quorum.

THE SPEAKER: If there is no objection from the House, the Report of the Committee on Credentials will constitute a roll call.

The first order of business is the Supplementary Report of the Council.

HENRY R. CARSTENS, M.D.: Mr. Speaker, the Council has nothing further to report.

THE SPEAKER: The Reference Committee on Reports of Standing Committees.

XI-3. ON STANDING COMMITTEE REPORTS (Syphilis Control, VIII-15 and Genito-Infectious Disease Program, VI-1)

E. D. SPALDING, M.D.: Taking up, first, the resolution on the genito-infectious disease program, introduced in the House of Delegates in its revised form this afternoon, which was again taken up by the Committee, I will read the resolution as a whole, as it is now amended:

WHEREAS, An expanded program for the control of the genito-infectious diseases throughout the states has been made possible by federal grants-in-aid to states to be used specifically for this purpose; and

WHEREAS, Upon State Health Departments has been placed the responsibility for the judicious and wise expenditures of such funds; and

WHEREAS, The organized medical profession of this state has likewise a responsibility in this particular problem, as it has in all other health problems affecting the people; and

WHEREAS, Because of the magnitude and scope of any statewide program endeavoring to control genito-infectious diseases, the House of Delegates of the Michigan State Medical Society recognizes the need for the fullest coöperation, aid and counsel from the practicing doctor of medicine and

WHEREAS, The proper control of these diseases depends upon adequate, continued treatment of the individual and the detection and treatment of infected contacts and

WHEREAS, The treatment of the infected individual is the province of the practicing doctor of medicine; and

WHEREAS, The modern technics employed in the treatment of genito-infectious disease requires a familiarity with such technics as well as a knowledge of the diseases themselves; therefore, be it

RESOLVED, That the House of Delegates of the Michigan State Medical Society endorse in their entirety the principles submitted, and further be it

RESOLVED, That the Michigan State Medical Society coöperate with the various agencies for the promotion of public health, both state and local, in the formulation of such programs as would appear to be advisable for the public good and the interest of sound medical practice through its delegated Committee on Syphilis Control, and further be it

RESOLVED, That it is the sense of this House of Delegates of the Michigan State Medical Society that the component County Medical Societies coöperate to the best of their individual facilities in an effort to insure the quality of service to be rendered in genito-infectious disease control programs, and further be it

RESOLVED, That it is the sense of this House that because of the potential danger of intravenous therapy, such treatment should be administered only by Doctors of Medicine, and that treatment of these infectious diseases by other than those qualified be condemned both from the viewpoint of the individual as well as the public health resulting hazard, and further be it

RESOLVED, That this House endorses effort on the part of the Syphilis Control Committee and the Legislative Committee or other such agencies as may be so delegated to eliminate the pernicious practices of those not qualified to treat these infectious diseases.

This resolution in its present revised form has been approved by the Committee, and I move its adoption.

DR. NOVY: I second the motion.

THE SPEAKER: It has been moved and supported to adopt this report. Are there any remarks?

If not, all in favor say "aye"; those opposed. It is carried.

XI-3. ON STANDING COMMITTEE REPORTS (Committee on Distribution of Medical Care, VIII-4)

DR. SPALDING: Supplementing the recommendation of the Reference Committee on the Reports of Standing Committees on the Report of the Committee on Distribution of Medical Care, which was given this afternoon, the Committee offers the following supplementary report:

Arising out of the discussion of the Report of the Committee on Distribution of Medical Care, the following points seem clear:

1. It is recognized that not all qualified physicians have been certified by a Specialty Board.
2. It is also recognized that the opportunities for formal academic preparation for certification by these Boards are very limited, and further, that the value of experience has not always been given adequate consideration.

To correct the above-mentioned faults in the existing situation, the Reference Committee offers the following resolution:

WHEREAS, now as never before, this country needs the concerted effort and wholehearted coöperation of American physicians, and

WHEREAS, Certification by specialty boards is being arbitrarily taken by government agencies as an imperative requirement for performance of many medical services, paid for by government funds, and

WHEREAS, Such work is increasing in amount and importance, and

WHEREAS, This policy works a hardship on many qualified physicians by excluding them from such work; therefore be it

RESOLVED, That the Michigan Delegates to the American Medical Association be instructed to propose to the House of Delegates of the A.M.A. that a committee of that House be created to confer with specialty boards, national organizations of specialists, and government agencies to effect some equitable adjustment of these difficulties and remove this potential source of dissension in the ranks of American Medicine.

Respectfully submitted,
EDWARD D. SPALDING, M.D., Chairman,
Reference Committee on Reports
of Standing Committees.

I move the adoption of this resolution.

The motion was seconded by Dr. Brasie of Genesee.

S. W. INSLEY, M.D. (Wayne): There has already been a modern movement in this country toward the organization of the general practitioners' groups. The surface of the possibility of that has barely been scratched. Dr. Bruce this afternoon mentioned an enlargement of the postgraduate training of these men. I wonder whether it might not be appropriate at this time to include, as an amendment to this proposition, that carefully organized groups of general practitioners' sections be also recognized in the solving of this problem.

I might add, further, that in Wayne County there is already a Section on General Practice set up.

THE SPEAKER: You have heard Dr. Insley's amendment. Is it supported?

G. L. MCCLELLAN, M.D. (Wayne): I support it.

THE SPEAKER: We will now vote on the amendment.

THE SPEAKER: All those in favor signify by standing up. Those who are not in favor will please stand. The amendment is lost.

We will now vote on the original motion. All in favor say "aye"; opposed. It is carried.

DR. SPALDING: Mr. Speaker, having voted on the resolution, I now move the acceptance of the Report of the Committee on the Distribution of Medical Care, with the modifications of this report as implied by the foregoing.

The motion was seconded and carried.

DR. SPALDING: I will now move the acceptance of the Reports of the Standing Committees as a whole.

The motion was seconded by Dr. Oakes, put to a vote and carried.

THE SPEAKER: Dr. Oakes, do you have a supplementary report?

XI-1. ON OFFICERS' REPORTS (President's Address, II)

E. A. OAKES, M.D.: In the mêlée this morning we missed one rather important recommendation by Dr. Corbus. I am going to include it here.

Your Committee further wishes to recommend for your adoption the suggestion of your President, Dr. Corbus, that a committee on Prelicensure Education be named with additional representation from the State Board of Registration in Medicine and the Michigan Hospital Association, the objective of which will be to develop a coöperative plan for interne training.

I move the adoption of this report.

The motion was seconded by Dr. Ledwidge of Wayne.

BURTON R. CORBUS, M.D.: May I speak on that?

THE SPEAKER: Yes, you may, Dr. Corbus.

DR. CORBUS: This was a conference committee which was formed last year of the two schools, and later added the Registration Board and the hospitals. My thought was that we would carry that committee in our JOURNAL and arrange to have it operate as the Joint Committee on Health Education is operated, with representatives from this Society to that committee.

THE SPEAKER: You have heard the supplementary report of the Reference Committee on Officers' Reports. Is there any further discussion?

All in favor will say "aye"; opposed the same. It is carried.

XI-6. ON RESOLUTIONS (Special Memberships, VI-3)

DR. MYERS: Your Committee on Resolutions wishes to report on the following resolution:

WHEREAS, The late Stuart Pritchard, M.D., through his work as Director of the W. K. Kellogg Foundation, rendered unusually meritorious service to organized medicine in the field of health education, preventive medicine and postgraduate education, and through his conscientious efforts helped to make the family physician and dentist the focus from which health education shall emanate, therefore, be it

RESOLVED, That in recognition of his many contributions to organized medicine, the late Stuart W. Pritchard, M.D., be elected to Honorary Membership, and that this posthumous award be transmitted to his family.

PAUL ENGLE, M.D., Delegate,
Eaton County,
LUTHER W. DAY, M.D., Delegate,
Hillsdale County.

That is signed by the Committee on Resolutions, and we have recommended the adoption of this resolution.

I move the recommendation be adopted.

The motion was seconded by Dr. Oakes, put to a vote and carried.

XIII. Elections

XIII-1. COUNCILOR SECOND DISTRICT

THE SPEAKER: The next will be the elections.

The first is the election of a Councilor from the Second District. J. E. McIntyre, M.D., is the present incumbent.

T. I. BAUER, M.D. (Ingham): This morning we of the Second District received a communication we were afraid we would receive but hoped we would not:

To the Delegates of the Second Councilor District:

I have not been, and am not now, a candidate to succeed myself to reëlection to The Council. I have served two terms, and that is enough. I am not a third-termite. I wish to thank you all for your loyal friendship and coöperation.

Cordially and sincerely,
J. E. MCINTYRE, M.D.

This came as a shock to us, but we were afraid it was coming. Earl has represented us for ten years, and we have been very proud of the service that he has rendered our district and to the State of Michigan Medical Society.

We were at a loss, until this morning we got an inspiration, so I would like to present as a candidate to the office of Councilor from the Second District, the name of a physician whom this morning the House of Delegates chose to honor, whose unselfish, meritorious service to the Michigan State Medical Society was recognized by the presentation of a special scroll, and who I feel can well represent not only the Second

Councilor District but serve the interest of the Society as a whole.

There are various reasons to support this man for the office of Councilor. The district consists of the counties of Eaton, Hillsdale, Ingham and Jackson, and not in twenty years have they been represented on The Council by a physician from the second-largest community in the district. I feel the Second District will have reason to be proud of his integrity in representing his own district and in safeguarding the welfare of the State of Michigan as a whole.

Therefore, I have the honor to place before the House of Delegates of the Michigan State Medical Society, the name of Philip Riley, M.D. This was unanimous.

LUTHER W. DAY, M.D. (Hillsdale): Mr. Speaker, I certainly support that nomination.

THE SPEAKER: Dr. Philip Riley has been nominated, and his nomination is supported. Are there any other nominations?

DR. BREAKEY (Ingham): Mr. Speaker, I move the nominations be closed.

The motion was seconded.

THE SPEAKER: It is moved and supported that the nominations be closed. All in favor of Dr. Riley as Councilor from the Second District will please say "aye"; those opposed. The motion is carried.

XIII-2. COUNCILOR THIRD DISTRICT

The next order of business is the election of a Councilor from the Third District. Wilfrid Haughey, M.D., of Battle Creek is the incumbent.

HARVEY HANSEN, M.D. (Calhoun): I would like to place in nomniation the name of Wilfrid Haughey, M.D., to succeed himself.

R. L. WADE, M.D. (Branch): I second the nomination.

C. K. VALADE, M.D. (Wayne): I move that the nominations be closed.

The motion was seconded by D. J. O'Brien, M.D., of Lapeer.

THE SPEAKER: All in favor of Dr. Haughey will say "aye"; opposed the same. The motion is carried.

THE SPEAKER: Will the Secretary cast the unanimous ballot?

It has already been cast in both cases.

XIII-3. COUNCILOR FIFTEENTH DISTRICT

Fifteenth District—Otto O. Beck, M.D., of Birmingham, incumbent.

C. T. EKELUND, M.D. (Oakland): A caucus of the delegates of the Fifteenth District reveals that they are unanimously in favor of the election of Otto Beck, M.D., to succeed himself. Dr. Beck has not filled out a complete term. We now want him to be elected to his own right. I nominate Dr. Beck.

P. L. LEDWIDGE, M.D. (Wayne): I second the nomination.

R. M. MCKEAN, M.D. (Wayne): Mr. Speaker, I move the nominations be closed, and the unanimous ballot be cast by the Secretary for the election of Dr. Beck.

The motion was seconded and carried, and the ballot was cast.

XIII-4. COUNCILOR SIXTEENTH DISTRICT

THE SPEAKER: The Sixteenth District.

ALLAN MCDONALD, M.D. (Wayne): It gives me great pleasure to place in nomination the name of Andrew S. Brunk, M.D.

DR. VALADE: I second the nomination.

R. M. MCKEAN, M.D. (Wayne): I move that the nominations be closed and the Secretary cast the unanimous ballot.

The motion was seconded and carried, and the unanimous ballot was cast.

THE SPEAKER: I declare A. S. Brunk, M.D., Councilor of the Sixteenth District.

XIII-5. DELEGATES TO A.M.A.

The next order of business will be the election of delegates to the American Medical Association. Nominations are now in order.

L. J. HIRSCHMAN, M.D. (Wayne): Mr. Speaker, in our representation in the House of Delegates of the American Medical Association, Michigan has been very, very much in the fore, and the reason for that is this: that we are doing as other state societies have been doing for many years; when we have a good man in office, we keep sending him back, unless for some reason of health, disinclination, or mischievous conduct in office he should not be sent back.

I would like to place in nomination a man who has shed great luster on our state, and I hope we can keep sending him back just as long as he wants to go, Henry A. Luce, M.D. (*Applause*).

C. K. VALADE, M.D. (Wayne): I second the nomination.

C. F. VALE, M.D. (Wayne): I move the nominations be closed and the Secretary be instructed to cast the unanimous vote.

THE SPEAKER: It is moved that the nominations be closed and the Secretary be instructed to cast the unanimous vote for Dr. Luce. All in favor say "aye"; contrary the same sign. It is carried.

Are there any further nominations?

RALPH H. PINO, M.D. (Wayne): Mr. Speaker, it seems as though there are very few hospital superintendents or hospital directors who take a definite interest in the practice of medicine. They do take an interest in the progress of the hospital and its affairs, but to be the superintendent of a hospital and at the same time to take a very definite interest in the practice of medicine in the county society and in the State Society is something that is just a little bit rare.

To have a superintendent of a hospital who is interested in the subject of medicine and who attends the meetings of the staff and discusses the medical problems and knows the medical problems is not so common, among hospital superintendents. Hospital superintendents who are politically inclined, politically inclined for the medical profession as well as for the hospital affairs, are not entirely usual.

Now, we have such a man in Wayne County, and we are proud of him. He has done a good job for us. He has been the superintendent of three of our largest hospitals here over a period of twenty-five years. I think that he is the superintendent of the largest hospital in the United States at this time.

We would like to have T. K. Gruber, M.D., continue as a delegate to the American Medical Association from Wayne County. We believe the rest of you would, too. I would like to place his name in nomination.

THE SPEAKER: Dr. Gruber has been nominated.

DR. MCKEAN: I would like to second the nomination of Dr. Gruber.

DR. VALADE: I move that the nominations be closed and the Secretary be instructed to cast the unanimous ballot.

The motion was seconded by Dr. McKean, put to a vote and carried.

THE SPEAKER: We are now waiting for further nominations.

J. M. ROBB, M.D. (Wayne): Mr. Speaker and Members of the House of Delegates: This is the first time I have appeared today to talk, contrary to my usual position. I deem it a great pleasure again to come to the fore for my good friend, Frank Reeder. He is a junior, not a senior like Dr. Luce, in the House of Delegates, but, believe me, he works. I have been interested in appearing down there a couple of times, and I have known that Dr. Reeder has been around. He has the unusual quality, too, of being able to handle a lot of political situations, and that, I am going to tell you, is the most important part of the whole pro-

gram. All of the things in the world are not accomplished by sitting by the fireside. One has, once in a while, to drift into other corners and pursue the things that one wants.

It is with very great pleasure that I present again the name of Frank E. Reeder, M.D., as Delegate to the American Medical Association.

D. R. BRASIE, M.D. (Genesee): We in Genesee heartily endorse Dr. Reeder's nomination, and know from upstate we could have no better representative. I second the nomination.

DR. VALADE: I move that the nominations be closed, and the Secretary cast the unanimous vote.

The motion was seconded, put to a vote and carried.

A. E. Catherwood, M.D., (Wayne): Mr. Speaker, in view of what has been said about the continuity of service by delegates from the State of Michigan to the A.M.A., I would like again to nominate Claude Keyport, M.D., of Grayling. He has been a representative of this State for eight years, and has done a very good job. I think he deserves to be sent back.

THE SPEAKER: Dr. Keyport has been nominated.

DR. OAKES: I move that the nominations be closed and the Secretary cast the unanimous ballot.

The motion was seconded by Dr. Valade, put to a vote and carried.

XIII-6. ALTERNATE DELEGATES TO A.M.A.

THE SPEAKER: The next order of business is the election of Alternate Delegates to the American Medical Association.

GEORGE J. CURRY, M.D. (Genesee): I would like to place the name of Dr. Robb in nomination.

J. M. ROBB, M.D. (Wayne): Mr. Speaker, I appreciate very much the fact that my name has been presented, but I have received considerable commendation at the hands of the profession, and I would much rather see someone else be an alternate. I, therefore, ask that my name be withdrawn.

DR. GRUBER: Mr. Speaker, I nominate one of the incumbents, R. H. Denham, M.D., of Grand Rapids.

THE SPEAKER: R. H. Denham, M.D., has been nominated. Any further nominations?

The terms expiring are those of R. H. Denham, M.D., Carl F. Snapp, M.D., and C. S. Gorsline, M.D.

A. V. WENGER, M.D. (Kent): I nominate Carl F. Snapp, M.D.

THE SPEAKER: Dr. Carl Snapp has been nominated. We need one more.

R. L. WADE, M.D. (Branch): I nominate Dr. Gorsline.

DR. VALADE: Mr. Speaker, may I move that the nominations be closed and the Secretary cast the unanimous ballot?

THE SPEAKER: It has been moved that the nominations be closed.

No, it is impossible in this, Doctor. If you will read on page 101 of the Handbook, it states that the alternate delegates have relative seniority according to the respective numbers of votes received by them. This question comes up every year.

DR. HIRSCHMAN (Wayne): Mr. Speaker, I move that, if there are no further nominations, the seniority be decided by lottery. We can suspend the rules and have these gentlemen determine their seniority by lot.

The motion was supported by Dr. Robb of Wayne.

THE SPEAKER: It has been moved and supported that the rules be suspended and the determination of seniority of Alternate Delegates be made by lot.

The motion was put to a vote and carried.

THE SPEAKER: Do the nominees wish to come up, or is it all right if the Speaker will appoint Dr. Kniskern to draw these? Dr. Kniskern, will you please draw?

Lots were drawn and the seniority, according to the drawing, is as follows: Dr. Snapp, Dr. Gorsline, and Dr. Denham.

THE SPEAKER: The next order of business is the election of a President-Elect.

XIII-7. PRESIDENT-ELECT

DR. BRASIE (Genesee): Mr. Speaker, it is a very great personal privilege to be permitted to present to this House the name of a gentleman eminently fitted by his experience and his service to the State Society, a distinguished son of an eminent father, Henry R. Carstens, M.D. (*Applause*)

THE SPEANER: Dr. Carstens has been nominated.

DR. LEDWIDGE: I move the nominations be closed and the Secretary instructed to cast the unanimous ballot.

The motion was put to a vote and carried.

THE SPEAKER: Dr. Ellet, please escort Dr. Carstens to the platform. (*Applause*)

Dr. Carstens was escorted to the platform.

The audience rose and applauded.

HENRY R. CARSTENS, M.D.: Mr. Speaker and Members: In view of the fact that you have heard me talk a great deal, I feel that in this case all I can say is to express my heartfelt thanks. It has been my privilege to serve as a member of the House of Delegates for a good many years, as your Vice Speaker, and as your Speaker, and on the Council for the past ten years. At least, I should have had the opportunity of becoming acquainted with some of the duties. I hope I shall not be remiss in filling the office to which you have elected me. I appreciate the honor. Thank you. (*Applause*)

Vice Speaker O'Meara took the chair.

THE VICE SPEAKER: Gentlemen, the next order of business is the election of a Speaker for the House of Delegates.

XIII-8. SPEAKER OF THE HOUSE OF DELEGATES

C. F. SNAPP, M.D. (Kent): Mr. Vice Speaker, it is customary in this august assembly that we give a man a second chance to make good. I think we ought to have O. D. Stryker, M.D., presiding over this assemblage next year.

I nominate Dr. Stryker for Speaker of the House of Delegates.

DR. ELLET (Berrien): Mr. Speaker, may I have the privilege of supporting that nomination?

DR. VALE (Wayne): I move the nominations be closed and the Secretary instructed to cast the unanimous ballot for the election of Dr. Stryker.

The motion was seconded, put to a vote and carried.

Dr. Stryker resumed the chair.

THE SPEAKER: Thank you, gentlemen.

The next order of business will be the election of a Vice Speaker of the House of Delegates.

XIII-9. VICE SPEAKER OF THE HOUSE OF DELEGATES

DR. NOVY (Wayne): Mr. Speaker, it gives me great pleasure at this time to put in nomination a man who I hope, at the next session of this body, will be Vice Speaker, that I may also have occasion to speak to him as I have this time—Dr. Spalding.

THE SPEAKER: Dr. Spalding has been nominated as Vice Speaker. Are there any other nominations?

DR. VALADE: I move the nominations be closed.

DR. ELLET (Berrien): Mr. Speaker, I would like to have the privilege of offering the name of the present incumbent as Vice Speaker, a man who has done his work well. I think he should be given consideration. I know we all love him.

I would like to nominate James J. O'Meara, M.D.

THE SPEAKER: Dr. O'Meara has been nominated. Any further nominations?

D. J. O'Brien, M.D. (Lapeer): I second the nomination of Dr. O'Meara.

The Speaker: Are there any further nominations?

Dr. Ledwidge (Wayne): I move that the nominations be closed.

The motion was seconded and carried.

The Speaker: I will appoint as tellers, Drs. Dutchess, A. V. Wenger, and D'Alcorn.

The ballots were distributed and the vote cast and the votes tallied.

The Speaker: Dr. O'Meara has been elected Vice Speaker. (*Applause*)

XIII-10. COUNCILOR FIRST DISTRICT

Dr. Foster has the resignation of Henry R. Carstens, M.D., as Councilor of the First District, which was given him this morning. Nominations are now in order for Councilor for the First District.

Dr. Gruber (Wayne): Mr. Speaker, I move we revert to the order of business of electing the Councilor for the First District.

The motion was seconded by Dr. Pino of Wayne, put to a vote and carried.

The Speaker: Nominations are now in order for Councilor for the First District.

G. L. McClellan, M.D., (Wayne): Mr. Speaker, I deem it a privilege to nominate a man from Detroit, who has served the profession of Michigan by serving the Wayne County Medical Society as Secretary, as President, as a member of the Board of Trustees. He has given generously of his time and very efficiently of his ability. We who have sat around the table with him know he has the welfare of the profession at heart. I believe he will be a credit to The Council of the Michigan State Medical Society.

I would like to nominate C. E. Umphrey, M.D.

The Speaker: C. E. Umphrey has been nominated.

E. D. Spaulding, M.D. (Wayne): Mr. Chairman, I second the nomination of Dr. Umphrey.

J. A. Kasper, M.D. (Wayne): I move the nominations be closed and that the Secretary cast the unanimous ballot.

The motion was seconded, put to vote and carried.

The Speaker: A motion is now in order to revert to the usual order of business.

The motion was seconded by Dr. Vale of Wayne, put to a vote and carried.

The Speaker: I would like to announce that after the close of this meeting, the Michigan State Medical Society invites the House of Delegates to the "After Glow." All delegates, officers, and members of the Detroit Committee on Arrangements are cordially invited to attend. I wish to thank all the delegates for their courtesy in making this meeting what I consider to be a great success.

Dr. Loupee: I wsh to move that the House of Delegates now formally acknowledge the service of all individuals and all groups who have acted to make this meeting a success. I include the radio, the newspapers, members of the Wayne County Society. I move that the credit of the success be attributed to them formally by this House of Delegates.

The motion was seconded by Dr. Snapp and carried.

XIV. Adjournment

Upon motion regularly made and seconded, the House of Delegates adjourned at ten thirty-five o'clock.

Mail your Preparedness Questionnaire to the A.M.A. today!

YOU AND YOUR BUSINESS

TESTIMONY BY HEALERS OF ANOTHER SCHOOL

Decisions have been handed down in several cases relative to osteopaths, chiropractors, and other non-medical practitioners giving expert testimony in malpractice cases. In the case of Forthofer v. Arnold (Ohio), 21 N.E. (2d) 869, the court relied for its decision on 21 R.C.L. 383, section 28, which states:

> In an action for malpractice a physician or surgeon is entitled to have his treatment of his patient tested by the rules and principles of the school of medicine to which he belongs, and not by those of some other school, because a person professing to follow one system or school of medicine cannot be expected by his employer to practice any other, and if he performs the treatment with ordinary skill and care in accordance with his system, he is not answerable for bad results.

This general rule was also adhered to in the case of Wemmett v. Mount, (Ore.) 292 P. 93, and Ness v. Yoemans (N.D.) 234 N.W. 75.

DO YOU KNOW HIS NAME?

Do you know the name of your State Senator? The name(s) of your State Representative(s)?

Despite the fact that the State Legislature has the power to alter the form and scope of medical practice, few doctors of medicine bother to communicate their views to their representatives at Lansing, according to the legislators themselves. A surprising indifference to the fate of their profession is shown in this apathetic attitude. Every two years, when the Legislature meets, a number of occasions arise when an unmistakable expression of professional opinion would have a decisive effect on the course of legislation affecting Medicine.

Get acquainted with your legislative representatives, and present to them the views of organized medicine. The voice of the individual is more effective than that of organizations because ballots of friends at home count most heavily with the politicians.

When a group of citizens fails to make its wishes known, legislators cannot be blamed if they obey the mandate of more articulate, if less unselfish, voters.

TWO DIFFERENT MATTERS

The medical profession's fight against state-managed medicine, on the one hand, and its request for recompense for services furnished to those on Welfare, on the other hand, may at first blush seem incongruous and inconsistent. However, the two matters refer to entirely different situations.

First: governmental medicine (so-called state-managed or socialized medicine) has to do with making physicians employes of the government, on salary.

Second: physicians who are in the private practice of medicine and who render service, for a fee, to those on Welfare, are acting as free agents, utilizing and maintaining the family-physician-patient relationship, and simply requesting recompense for a service rendered to a person who is part of a group which cannot pay its own way, and must look for help to some other agency (in this case, to government). The physician is not an employe of government or the Welfare Commission or of any agency of government; he remains an independent contractor with his rights as a private practitioner of medicine unimpaired and inviolate.

WHEN YOU LEASE OFFICE SPACE

When you sign a lease for rental of office space, it is quite a common practice for the real estate agency to include a clause in the fine-print section which states that you assume all liability that would normally accrue to the owner of the building, as for example injury to a patient who might be hit by a piece of broken window glass in your office. The average public liability policy will not cover such assumed liability unless it is specifically endorsed for that purpose. All liability policies contain a clause reading somewhat as follows: "The insurance under this policy does not apply to liability assumed by the insured under any contract or agreement." If this kind of loss is of concern to you, it would be well to examine carefully both your lease agreement and your public liability insurance policy, according to a bulletin from the Cincinnati Academy of Medicine.

MICHIGAN'S DEPARTMENT OF HEALTH

HENRY A. MOYER, M.D., Commissioner, Lansing, Michigan

POLIO HITS 497 CASES

Continuing the rapid rise of the last two weeks of August, poliomyelitis cases in September went to the year's peak and made September the second highest month in reported cases that the state has known.

Provisional figures show 497 cases, exceeded only by the September total of 577 cases in the record year of 1931. The month's peak of 154 cases reported for the second week was also higher than any other week except the third week in September, 1931, when 170 cases were reported.

September reports put the 1940 total more than 100 cases ahead of last year at this time, just 60 cases short of the 904 reported in 1939 for the year. That total was second only to the 1931 record of 1,137 cases.

PEDIATRIC INTERNESHIPS

Planned to meet needs of physicians in rural practice, a series of 30-day postgraduate interneships in pediatrics has been arranged at Children's Hospital of Michigan, at Detroit. Coöperating are the Michigan Department of Health, the Department of Pediatrics at Wayne University Medical School, and the hospital.

Applications for appointments during the coming year are now being made to Dr. Lillian R. Smith, Director of the Bureau of Maternal and Child Health, Michigan Department of Health. The endorsement of local medical societies is required for appointments. There is no cost to the physician except for transportation. Appointees will live at the hospital. Only one man at a time can be accepted.

The interneships are possibly unique in this country, for the physician appointed is not expected merely to observe, but actually to practice. He will work in the out-patient department, clinics and wards. Every attempt will be made to teach technics in pediatrics which can be put in use in country and small town practice. Dr. James L. Wilson, Assistant Medical Director, Children's Hospital of Michigan, Associate Professor of Pediatrics, Wayne University Medical School, will be in charge of the instruction.

TYPHOID

Typhoid fever cases reported from June through September have held to low figures, 20 or less per month. Last year, scattered cases in August sent that month's total to 42. In October, an outbreak at the Ypsilanti State Hospital was largely responsible for a reporting of 42 cases. Cases this year are: June, 8; July, 18; August, 16; September, 20.

RECORD LOW PNEUMONIA MONTHS

In the five-month period from last December through April which usually accounts for two-thirds of the annual lobar pneumonia mortality, deaths dropped to record low figures in three successive months and approached record lows in the other two.

Figures for this period and averages for the preceding ten-year period follow:

LOBAR PNEUMONIA DEATHS

	1939-40	Ten-Year Average
December	159	205
January	173	249
February	142	226
March	127	254
April	107	219

Serum and drug therapy is at least in part responsible for the reduction of pneumonia mortality. The figures are the first decisive showing from Michigan statistics indicating the life saving powers of antipneumococcic serum and drugs of the sulfonamide group, which lately have been widely used in the treatment of the pneumonias.

The record low months were those of February, March and April, the April total being 30 per cent under the previous ten-year low.

PERSONNEL CHANGES

Dr. Buell H. Van Leuven, who in 25 years of private practice at Petoskey served five terms as mayor, has been named acting director of the Menominee County Health Department, effective October 1. He succeeds Dr. C. C. Corkill who is on leave of absence for a year at Johns Hopkins University. Dr. Van Leuven served for 16 years as a councilor of the MSMS and a year as president of the Northern Michigan Medical Society. He left his practice last year to take public health studies at the University of Michigan.

Dr. Lorin E. Kerr has been named acting director of the Iron County Health Department, succeeding Dr. T. E. Camper, who is on leave of absence for a year at the University of Michigan. The appointment became effective October 1. Dr. Ker has been an assistant to Dr. C. D. Barrett, director of the Ingham County Health Department and MDH training center.

Dr. Albert C. Edwards, supervisor of local health service for the Wisconsin State Board of Health, will go to White Cloud to become the director of District Health Department No. 5 (Lake, Newaygo and Oceana counties) starting October 15. He succeeds Dr. Richard Sears, who in September was appointed director of the Muskegon County Health Department.

IN MEMORIAM

John C. Smith, of Jackson Michigan, was born April 17, 1882 at Guide Rock, Nebraska, and was graduated from the University of Michigan in 1907. Doctor Smith entered general practice in Jackson. In 1913, he moved to Florida where he practiced for one year. Thereafter he entered Eye, Ear, Nose, and Throat postgraduate clinics in New York, Chicago and Vienna. He returned to Jackson in 1915, where he practiced until the time of his death, September 3, 1940. Dr. Smith was on the staff of both Foote and Mercy Hospitals in Jackson.

H. Wellington Yates, Past President of the Wayne County Medical Society, Detroit, was born February 24, 1867 near Galt, Ontario and was graduated from the Detroit College of Medicine and the University of Vienna. For years he was head of the department of gynecology and obstetrics at the Detroit College of Medicine and at the time of his death was a member of the staff of Women's Hospital. He held an honorary fellowship in the American Association of Obstetricians, Gynecologists and Abdominal Surgeons. Dr. Yates died in Harper Hospital on October 13, 1940.

✶ COUNTY AND PERSONAL ACTIVITIES ✶

J. Milton Robb, M.D., Detroit, was elected a vice president of the National Academy of Otolaryngology at its meeting in Cleveland the week of October 7, 1940.

* * *

Wilfrid Haughey, M.D., Councilor of the 2nd District, Battle Creek, spoke to the Woman's Auxiliary of the Jackson County Medical Society on Tuesday, October 15. His subject was "Opportunities for the Woman's Auxiliary."

* * *

Burton R. Corbus, M.D., Grand Rapids, addressed the American School Health Association at its meeting of October 10 in Detroit in the panel "Evaluation of School Health Practices." Doctor Corbus's special topic was "School Health Practices as Related to the Private Practitioner."

* * *

Frank Van Schoick, M.D., Jackson, Chairman of the Child Welfare Committee of the MSMS, will represent the State Society at the joint meeting of the Bureau of Maternal and Child Health and the Bureau of Public Health Nursing of the State Health Department to be held in Lansing, November 28 and 29.

* * *

R. C. Huston, president of the Michigan State Board of Examiners in the Basic Sciences, reports that on June 28 and 29, 1940, the basic science examination was given to 76 persons, of which 53 passed and 23 failed. Of the 23 who failed, 16 failed in one subject only.

The next examination to be given by the Basic Science Board will be on February 14 and 15, 1941, to be given concurrently at Ann Arbor, Detroit and East Lansing.

* * *

New County Medical Society.—Pursuant to action of the House of Delegates on September 24, 1940, in Detroit, granting a charter to the Huron County Medical Society, the organizational meeting was held on October 10. The newly elected officers are President, J. Bates Henderson, M.D., Pigeon; Vice President, W. B. Holdship, M.D., Ubly; Secretary-Treasurer, Roy R. Gettel, M.D., Kinde; Chairman, County Medical Preparedness Committee, Willet Herrington, M.D., Bad Axe; Delegate, C. W. Oakes, M.D., Harbor Beach; and Alternate Delegate, C. A. Scheurer, Pigeon .

* * *

The Second Venereal Disease Clinic Day was held on November 7 by the Ingham County Medical Society in Lansing. The subject under discussion was "Gonorrhea." Guest speakers included R. A. Vonderlehr, M.D., Washington, D. C.; Adolph Jacoby, New York City; Percy Pelouse, M.D., Philadelphia; and V. Robers Deakin, M.D., St. Louis, Missouri. A movie was also presented by the Michigan Department of Health. The day was climaxed by a public meeting at which Dr. Vonderlehr spoke on "Present Day Venereal Disease Control." Physicians from all the nearby counties were invited guests.

The State Bureau of Social Security, which administers aid to dependent children in Michigan, is seeking the coöperation of physicians in the state in furnishing reports as to the physical or mental incapacity of parents of such children.

In order to be eligible for assistance, such children must be deprived of parental support or care by reason of the death, continued absence from the home, or physical or mental incapacity of a parent. In determining whether the parent is so incapacitated, it is necessary to ask for reports from the family physician with respect to the condition of the parent. The State Bureau of Social Security would appreciate it highly if the physicians throughout the state would coöperate in furnishing such reports.

* * *

Joseph Stokes, Jr., M.D., of Philadelphia, one of the guest essayists on the 1940 Diamond Jubilee program of the Michigan State Medical Society, has requested that credit be given to Dr. Geoffrey Rake, Dr. Morris Shaffer, Gerald O'Neil and the Squibb Institute for Medical Research in the résumé of his paper, published in the September JOURNAL, as this résumé was the first mention of the clinical studies of Drs. Rake, Shaffer, O'Neil and the Squibb Institute for Medical Research published in any journal. This correction of the résumé is presented in order that full credit may be given to these physicians and to the Institute.

* * *

The Civil Service Commission announces that enough applications have been received to meet the prospective need for temporary and part-time civilian medical officers in connection with the Army expansion. Receipt of applications closed Monday, October 14.

The Commission calls attention to the fact, however, that there is an urgent need for medical officers and senior and associate medical officers to fill permanent positions in other agencies. Applications will be received until further notice. The positions pay from $3,200 to $4,600 a year. Fourteen specialized branches of medicine are included.

There is also an urgent need to fill junior medical officer positions at $2,000 a year at St. Elizabeths Hospital, Washington, D. C.

Full information and application forms for these examinations may be obtained from the U. S. Civil Service Commission, Washington, D. C.

* * *

Appearances of L. Fernald Foster, M.D., Bay City, Secretary of the Michigan State Medical Society, for the past several months include the following: May 15—Oceana and Newaygo County Medical Societies; May 16—Shiawassee County Medical Society; May 18—St. Vincents Nurses' Graduation, Toledo, Ohio; May 21—Lenawee County Medical Society; May 22—St. Joseph County Medical Society; May 29—Alpena County Medical Society; August 17—American Legion Child Welfare Conference; September 19—Saginaw Kiwanis Club; October 3—Bay City Kiwanis Club.

Doctor Foster is scheduled to appear as guest speaker at the 19th Annual meeting of the Michigan Society for Crippled Children to be held in Kalamazoo, November 15 and 16. He will participate in the symposium on Michigan's Crippled Child Problem.

* * *

Industrial Health and Safety Symposium.—Keeping pace with the increasing importance of Saginaw as an industrial center and to further the interest of National Defense, the Saginaw County Medical Society is arranging for an all-day Symposium on Industrial Health and Safety to be held at the Bancroft Hotel on November 12, 1940. This is the first attempt by a County Medical Society in the United States to sponsor such a program. Ten or more nationally known speakers will be on the program to cover all phases of in-

dustrial health and safety and their relationship to manufacturing, personnel and National Defense. There will be morning, luncheon, afternoon and evening sessions. All medical clubs, societies and individuals in the Saginaw Valley interested in the various phases of industrial health and safety will be invited to attend. The details are being arranged by the Industrial Health Committee consisting of Dr. R. D. Mudd, Chairman, Dr. V. L. Hill, Dr. E. D. McKinnon and Dr. D. E. Thomas. The Industrial Nurses of Michigan will hold their annual meeting at the same time.

* * *

Captain L. A. Potter, Inspector for the State Health Department, has been busy. Distributors of the book "The Library of Health" on a house-to-house basis were apprehended in Lansing early in September. It seems that the book, which was being sold for $21.00 answered all questions relative to health. One lady who was selling the book stated that she was a practical nurse, having obtained all of her nursing training from the book!

A Max W. Frank of Jackson was convicted by the Jackson Circuit Court jury on October 1, of practicing medicine without a license, on evidence supplied by Captain Potter. Mr. Frank was sentenced on October 5, to pay $100 fine and costs and given two years probation.

* * *

Doctors at Work is the title of the sixth annual series of dramatized radio programs to be presented by the American Medical Association and the National Broadcasting Company.

The series will open *Wednesday, November 13, 1940,* and run for thirty consecutive weeks, closing with a broadcast from the A.M.A. meeting at Cleveland, on June 3, 1941. The program is scheduled for 10:30 P.M. Eastern Standard Time (9:30 Central; 8:30 Mountain; 7:30 Pacific time) over the Blue network, other NBC stations and Canadian stations.

The programs will dramatize what modern medicine offers the individual in the way of opportunities for better health and the more successful treatment of disease. Incidental to this main theme, the programs will explain the characteristics of the different fields of modern medicine and its specialities.

Descriptive posters for local distribution may be had gratis from the Bureau of Health Education, American Medical Association, 535 N. Dearborn St., Chicago. Program titles will be announced weekly in *The Journal of the A.M.A.* and monthly in *Hygeia,* the Health Magazine.

* * *

MSMS DISTRICT MEETINGS

Seven District meetings have already been held as the November JOURNAL goes to press.

The *First and Sixteenth Districts* held a combined meeting on November 4 at the Detroit Art Institute. A. S. Brunk, M.D., Chairman of The Council, presided at the meeting. The speakers included President-elect H. R. Carstens, M.D., Detroit; Secretary L. Fernald Foster, Bay City; President P. R. Urmston, Bay City; Councilor C. E. Umphrey of Detroit and Executive Secretary Wm. J. Burns, Lansing. Also present were Councilor O. O. Beck, Birmingham, and Councilor T. E. DeGurse, Marine City.

At the *Third District* meeting held in Battle Creek on October 22, Wilfrid Haughey, M.D., Battle Creek, presided. Those who participated in the program in-

cluded Secretary L. Fernald Foster, Bay City; Roy Herbert Holmes, M.D., Muskegon, and Vernor M. Moore, M.D., Grand Rapids.

The *Fourteenth District* meeting was held in Ann Arbor on October 8, with Councilor H. H. Cummings, Ann Arbor, presiding. Among the speakers on this program were President-elect Henry R. Carstens, Detroit; Secretary L. Fernald Foster, Bay City; Council Chairman A. S. Brunk, Detroit; and Executive Secretary Wm. J. Burns, Lansing.

The *Fourth District* meeting was presided over by Councilor R. J. Hubbell, Kalamazoo, and was held in Kalamazoo. The program of this meeting consisted of talks by President-elect Henry R. Carstens, Detroit; Secretary L. Fernald Foster, Bay City; Legislative Committee Chairman Harold A. Miller, Lansing; Councilor V. M. Moore, Grand Rapids; and Executive Secretary Wm. J. Burns, Lansing.

The *Fifth District* meeting met in Grand Rapids on October 29, Councilor V. M. Moore, presiding. The speakers included President-elect Henry R. Carstens, Detroit; Councilor Wilfrid Haughey, Battle Creek; and Secretary L. Fernald Foster, Bay City. Among the honor guests were Speaker of the House of Delegates O. D. Stryker, Fremont; Councilor Roy Herbert Holmes, Muskegon; Burton R. Corbus, M.D., and Councilor R. J. Hubbell, Kalamazoo.

The *Sixth District* meeting was held in Owosso on October 29, councilor Ray S. Morrish, Flint, presiding. Speakers included Councilor R. C. Perkins, M.D., Bay City; H. A. Miller, M.D., Lansing; Council Chairman A. S. Brunk, Detroit; and Executive Secretary Wm. J. Burns, Lansing. Among the honor guests were Councilors W. E. Barstow, St. Louis; T. E. DeGurse, Marine City.

Other District Meetings are being arranged and it is anticipated that all of the District meetings will have been held by the end of November. A special invitation to each physician to attend his important district meeting is being mailed by President Urmston.

* * *

COUNTY SOCIETY MEETINGS

Bay—Wednesday, October 23—Wenonah Hotel, Bay City—Speaker: Stanley W. Insley, M.D., Detroit, on "Clinical Management of Allergic Diseases."

Berrien—Wednesday, August 7—Berrien Hills Country Club—Ladies' Night—Speaker: George Green, M.D., South Bend, Indiana, on a surgical subject. Thursday, September 5, Hotel Whitcomb, St. Joseph—movies on Anemia and Amoebiasis. October 2—Four Flags Hotel, Niles—Speaker: J. Bailey Carter, M.D., Chicago.

Calhoun—Tuesday, October 1—Hart Hotel, Battle Creek—Speaker: Charles F. McKhann, M.D., Ann Arbor.

Ionia-Montcalm—Tuesday, October 8—Lakeview—Speaker: George H. Southwick, M.D., Grand Rapids, on "The Acute Abdomen."

Jackson—Tuesday, October 15—Jackson—Speakers: Norman Westlund, M.D. and Wm. H. Kelly, M.D., a Mental Hygiene Symposium.

Kalamazoo—Tuesday, October 15 — Kalamazoo — Fourth District meeting.

Kent—Tuseday, October 8—Grand Rapids—Speaker: Walter Palmer, M.D., Chicago, on "Treatment of Gastric Disease."

O.M.C.O.R.O.—Wednesday, August 21—Grayling—Speakers: P. R. Urmston, M.D., L. Fernald Foster, M.D., and R. C. Perkins, M.D., of Bay City.

Oakland—Wednesday, October 2—Routunda Inn, Pine Lake—Speaker: Harther L. Keim, Detroit, on "Management of the more Common Dermatoses."

St. Clair—Tuesday, October 8—Port Huron—Speaker: S. E. Gould, M.D., Eloise, on "Pathologic Basis of Heart Disease."

Shiawassee—Thursday, October 17—Owosso—Speaker: Kenneth E. Markuson, M.D., Lansing, on "Industrial Health."

Washtenaw—Tuesday, September 10—Ann Arbor—Symposium on Heart Disease in the form of a "Information Please" quiz, conducted by Richard McKean, R. L. Novy, Ed. Spalding, and Douglas Donald all of Detroit. Tuesday, October 8—Ann Arbor—14th District Meeting.

Wayne—Monday, October 7—Detroit — Speaker: Nathan Van Etten, M.D., New York, President of the AMA, "Medical Horizons"—Also colored movies of WCMS 1940 Golf Tournament. October 14—Detroit—Speaker: Frank H. Bethell, M.D., Ann Arbor, "Anemias Related to the Nutritional Deficiencies with Particular Reference to Pregnancy." October 21—Detroit—Speakers: Edgar E. Martmer, M.D., J. A. Johnston, M.D., J. A. Molner, M.D., and W. C. C. Cole, M.D., all of Detroit. October 28—Detroit—Speaker: James T. Priestley, M.D., Rochester, Minnesota—on "Surgical Procedures on the Genito-Urinary Tract."

CONVENTION ECHOES

A total of 2,561 registered at the Diamond Jubilee Convention of the Michigan State Medical Society (not including the members of the Woman's Auxiliary). This figure includes 1,813 members of the MSMS, plus exhibitors and guests.

* * *

The 1,813 members of the MSMS who registered at the Detroit Convention came from every corner of the state. The following cities were represented as follows: Ann Arbor, 41; Battle Creek, 31; Bay City, 17; Dearborn, 12; Detroit, 949; Flint, 77; Grand Rapids, 57; Jackson, 20; Kalamazoo, 27; Lansing, 48; Monroe, 7; Mount Clemens, 13; Muskegon, 15; Pontiac, 38; Port Huron, 13; Saginaw, 34; and Ypsilanti, 8. The balance of those registering came from towns and villages in all parts of the State.

* * *

The various specialties were represented at the 1940 Convention, according to a breakdown of the figures, as follows: General Medicine, 1,040; Surgery, 346; Obstetrics and Gynecology, 121; Ophthalmology and Otolaryngology, 145; Pediatrics, 89; Dermatology and Syphilology, 38; and Radiology, Pathology and Anesthesia, 60.

* * *

Lt. Col. Harold A. Furlong, M.D., addressed the nearly 1,000 physicians who attended the Smoker on Thursday, September 26, outlining the highlights of medical preparedness.

* * *

Joseph Stokes, Jr., M.D., Philadelphia, recently returned from a tour of France with a service commission, provided another highlight of the Smoker by relating some of his experiences and observations in war-torn Europe.

* * *

More than 300 office secretaries of physicians attended the "Symposium on the Business Side of Medicine" held on September 24.

* * *

The Coca-Cola Company dispensed 3,024 bottles of Coca-Cola to thirsty physicians during the three days of the convention.

R. B. Davis Company distributed 1,300 sample cups of Cocomalt at the convention.

Pet Milk Company supplied physicians with approximately 4,000 of the familiar Pet Milk cans, in miniature.

Philip Morris passed out 9,656 cigarettes as samples during the convention.

The James Vernor Company served 1,800 cups of hot and cold Vernor's Gingerale.

* * *

Miss Marguerite Stewart, representing the American Safety Razor Corporation, traveled from New York to Detroit especially to view the MSMS exhibits and to attend the Society's dinner.

* * *

Michigan newspapers gave nearly 800 column inches to the MSMS Diamond Jubilee Convention or approximately 7,200 lines—and this despite war, politics and pretty girls!

* * *

The 1940 Golf Champion of the Michigan State Medical Society is J. H. Albers, M.D. of East Lansing, who won the President's Trophy at the 4th Annual Golf Tournament of the MSMS held at the Detroit Golf Club, September 23, with a low gross of 78. Other prize winners at the 1940 Tournament included C. D. Brooks, M.D., J. E. Hauser, M.D., John M. Murphy, M.D., Don Jaffar, M.D., all of Detriot, R. B. Harkness, M.D., Hastings; E. F. Sladek, M.D., Traverse City; L. J. Morand, M.D., D. P. Foster, M.D., George VanRhee, M.D., M. E. Danforth, M.D., Herman Scarney, M.D., A. E. Catherwood, M.D., H. F. Dibble, M.D., and C. D. Benson, M.D., all of Detroit; Philip A. Riley, M.D., Jackson; and B. B. Bushong, M.D., Traverse City.

STOLEN: Two Binocular Zeiss microscopes, numbers 177235 and 177655. If any physician or hospital gains knowledge of these microscopes, please wire Superintendent, Hurley Hospital, Flint, Michigan.

READING NOTICES

NEW LOCATION

Since November 1, 1940, the G. A. Ingram Company has been located in its new, fully modernized quarters at 4444 Woodward Avenue, Detroit, opposite the Wayne County Medical Society. The telephone number, Temple 1-6880, is the same as that used in the former location.

It is felt that the new location will greatly convenience members of the profession due to central location and proximity to a number of the major hospitals. Ample parking space is available in the rear of the store.

Permanent displays of furniture and equipment will be available for inspection. A cordial invitation is extended to all physicians to inspect the new facilities at 4444 Woodward Avenue.

SQUIBB RELEASES SULFATHIAZOLE

Sulfathiazole has been released for sale by E. R. Squibb & Sons, New York, in the form of 0.5 gram scored tablets for oral dosage and in crystals for compounding prescriptions and for determination of blood concentration.

Sulfathiazole has received extensive clinical trial and is a noteworthy advance in the chemotherapeutic treatment of pneumococcal and staphylococcal infections. It is the third of the "sulfonamide derivatives" to be released for sale by Squibb, the others being Sulfanilamide and Sulfapyridine. Sulfathiazole is believed to have the following advantages over Sulfapyridine:

1. More uniform absorption. 2. Less conjugation after absorption, so that a higher proportion of the total drug in the body-fluids is chemotherapeutically

active. 3. Less tendency to cause serious nausea or vomiting. 4. Greater effectiveness against staphylococcal infections.

* * *

LIVER EXTRACTS

Since the demonstration of the effectiveness of liver in pernicious anemia by Minot and Murphy and the early chemical work on this substance by Cohn and his co-workers, there has been steady progress toward the purification and eventual isolation of this substance. In order to simplify identification of various fractions now in general use, Eli Lilly and Company has revised its labels and the names identifying certain of the Liver Extracts, Lilly.

The fraction earlier supplied in powder as Liver Extract No. 343 is now designated Liver Extract, Lilly, each 12.75 Gm. or three vials containing 1 U.S.P. unit for oral administration. Ampoules Solution Liver Extract, 1 U.S.P. unit per c.c., is identical with the product formerly entitled Solution Liver Extract, Lilly, and Ampoules Solution Liver Extract, 2 U.S.P. units per c.c., is the product previously available as Solution Liver Extract Concentrated, Lilly. Solution Liver Extract Purified is now marketed as Ampoules Solution Liver Extract, 15 U.S.P. units per c.c.

* * *

PREVENT DEFORMITIES

No antiricketic substance will completely straighten bones that have become grossly misshapen as the result of rickets. But Oleum Percomorphum can be depended upon to prevent ricketic deformities, if given early and in adequate dosage. Be sure the antiricketic agent which you recommend is not limited by tolerance or bulk so that it can be given in quantities sufficient to arrest the ricketic process promptly, with the result that the bones are sufficiently calcified to bear weight or muscle-pull and hence do not become deformed.

* * *

VITAMIN-FREE FOODS FOR RESEARCH!

A recent announcement by the Research Laboratories of the S.M.A. Corporation reveals that they are now in a position to provide vitamin-free casein and other vitamin-free foods for experimental purposes to researchers who have previously been obliged to manufacture these items for private use.

For many years the S.M.A. Corporation has been producing these foods exclusively for use in their laboratories. Now, with the expansion of their own facilities and the realization of the convenience to others engaged in laboratory work this offer is made to provide vitamin-free diets at an exceptionally reasonable cost. Quantities of one, five, ten or 100 pounds or more may be ordered directly from the Research Laboratories, S.M.A. Corporation, Chagrin Falls, Ohio.

* * *

E. V. FRAENKEL ELECTED PRESIDENT

Frederick Stearns & Company of Detroit announced on September 24, 1940 the election of Mr. E. V. Fraenkel as President of the Company. Mr. Fraenkel was formerly General Manager of Stearns, having risen from the ranks to that position.

A native of Australia, Mr. Fraenkel received his education in that far-off country, and started his career as a detail and salesman there.

Have you completed
your
Preparedness Questionnaire?

THE DOCTOR'S LIBRARY

Acknowledgement of all books received will be made in this column and this will be deemed by us as a full compensation of those sending them. A selection will be made for review, as expedient.

MODERN DERMATOLOGY AND SYPHILOLOGY. By S. William Becker, M.D., Associate Professor of Dermatology and Syphilology, Kuppenheimer Foundation, University of Chicago, and Maximillian E. Obermayer, M.D., Assistant Professor of Dermatology and Syphilology, Kuppenheimer Foundation, University of Chicago. 461 Illustrations in text. 32 full color plates. Philadelphia, London, Montreal, J. B. Lippincott Company, 1940. Price: $12.00.

This is a streamlined, completely modern textbook on dermatology almost universally praised by the dermatologists. The authors have taken advantage of the newer approaches towards cutaneous disease complexes and have arranged the material to correspond. They have arranged the material from the functional point of view and "where this has been impracticable, dermatoses have been grouped according to common etiology or based on diagnostic consideration." The very rare conditions are not included thus making its use simpler for the general practitioner who desires a new book on dermatology. The chapter on industrial dermatoses, which is at present of such intense interest and of great prominence, is splendidly handled. The plates are especially well selected. It is easy to recommend this book to any physician.

AN ANATOMICAL ANALYSIS OF SPORTS. By Gertrude Hawley, M.A., Formerly in charge of Physical Education of Women at Northwestern and Stanford Universities. Author of "The Kinesiology of Corrective Exercise." New York, A. S. Barnes and Company, 1940. Price: $3.00.

This book is of more interest to athletic directors than to physicians although to those whose professional work takes them into contact with high school and college athletics it may answer some of the questions whose answers are not easily available through current textbooks. The muscles which are especially used in various sports are named and their actions described. The reasons for certain types of accidents and injuries which occur in the various sports are also explained on an anatomical basis. There is likely some advantages in this book to the physician interested in rehabilitation of patients with muscular impairment.

SIMPLIFIED DIABETIC MANUAL. With 163 international recipes (American, Jewish, French, German, Italian, Armenian, etc.) By Abraham Rudy, M.D., Associate Physician and Chief of the Diabetic Clinic, Beth Israel Hospital, Boston; Instructor in Medicine, Tufts College Medical School; Consultant in Diabetes, Jewish Memorial Hospital, Roxbury, Mass.; and Jewish Tuberculosis Sanatorium, Rutland, Mass. Introduction by Dr. Frederick M. Allen. New York, M. Barrows & Company, Inc., 1940. Price: $2.00.

This volume has been offered for the use of the diabetic patient. It contains the usual instructions regarding the disease and is written in a simple and readable manner. Besides the usual tables and recipes, a considerable number of recipes are included to make it possible for the patient with racial or religious restric-

tions to enjoy his choice dishes without undue harm to his diabetes. This book should be especially valuable to the Jewish diabetic.

GYNECOLOGICAL AND OBSTETRICAL PATHOLOGY. With Clinical and Endocrine Relations. By Emil Novak, A.B., M.D., D.Sc. (Hon. Dublin), F.A.C.S., Associate in Gynecology. The Johns Hopkins Medical School; Gynecologist, Bon Secours and St. Agnes Hospitals, Baltimore; Fellow, American Gynecological Society, American Association of Obstetricians, Gynecologists and Abdominal Surgeons and Southern Surgical Association; Honorary Fellow, Royal Institute of Medicine, Budapest; Sociedad d'Obstetricia et Ginecologia de Buenos Aires; Central Association of Obstetricians and Gynecologists; Texas State Association of Obstetricians and Gynecologists; Past Chairman, Section on Gynecology and Obstetrics, American Medical Association. With 427 Illustrations. Philadelphia and London, W. B. Saunders Company, 1940.

Novak says that here he has taken a middle course between a brief and superficial volume of but little value to those really interested and an exhaustive and encyclopædic work which would be of little practical assistance. He has ably accomplished this purpose. It is written with the emphasis on gross and histopathology of these conditions and is profusely illustrated with microphotographs. To the studious physician who is interested in modern investigation of pelvic disease this book is indispensable.

THE ERA KEY TO THE USP XI AND NF VI. Fifth Edition. Revised by Lyman D. Fonda, Professor of Pharmacy, Brooklyn College of Pharmacy, Long Island University. Newark, N. J., The Haynes and George Co., Inc., 1940. Price: $1.00.

The fifth edition of this condensed pharmacopœia contains many tables, lists and glossaries which will provide the needed source for information regarding all except the rarest of the drugs. In a very small size, there are many times when it might be valuable and yet use very little space in the doctor's bag or library.

THE HEAD AND NECK IN ROENTGEN DIAGNOSIS. By Henry K. Pancoast, M.D., Late Professor of Radiology and Director of the Department of Radiology, University of Pennsylvania; Eugene P. Pendergrass, M.D., Professor of Radiology and Director of the Department of Radiology, University of Pennsylvania; J. Parsons Schaeffer, M.D., Ph.D., Professor of Anatomy and Director of the Daniel Baugh Institute of Anatomy, Jefferson Medical College. Springfield, Illinois and Baltimore, Maryland; Charles C. Thomas. Price: $12.50.

These authors, who are among the best known in their field, have produced a volume which ties in the roentgenological findings with the basic sciences. The completeness and yet the ready accessibility of this volume is astounding. While it is a "must" book for the roentgenologist and the specialist in eye, ear, nose and throat, it is a much needed reference book for the orthopedist, traumatic surgeon, the neurologist, dentist and any practitioner who has more than a casual interest in this field.

THE DIAGNOSIS AND TREATMENT OF CARDIOVASCULAR DISEASE. By Fifty-Six Distinguished Authorities. Edited by William D. Stroud, B.S., M.D., F.A.C.P., Professor of Cardiology, University of Pennsylvania Graduate School of Medicine; President of the American Heart Association; Treasurer and Member of Board of Regents, American College of Physicians; Licentiate of the National Board of Medical Examiners and the American Board of Internal Medicine; Cardiologist to the Pennsylvania, Graduate, Bryn Mawr, Ab-

ington Memorial, St Christopher's and Children's Heart Hospitals. Fully Illustrated. Two volumes. Philadelphia: F. A. Davis Company, 1940. Price: $18.00.

William D. Stroud and fifty-five collaborators, including most of the leading cardiologists of the civilized world, have produced a complete two-volume text on all cardiovascular diseases. According to the author this is the first time that a comprehensive volume has been published. It has been kept quite practical in its character and is rather easy to read and understand. Especially interesting chapters are: Beck on "Surgery of the Heart and Pericardium"; Grant on "Relief of Pain in Angina Pectoris"; Soma Weiss on "Heart and Deficiency Diseases"; Allen on "Normal Blood Pressure and Its Variations"; Steiglitz on "Hypertensive Arterial Disease"; Buerger on "Thromboangiitis Obliterans"; de Takats on "Vascular Anomalies" and on "Varicose Veins"; Sprague and White on "Introduction to Diseases of the Cardiovascular System"; Paul on "The Epidemiology of Rheumatic Fever"; Dock on "Bacterial Endocarditis"; Stokes on "The Treatment of Cardiovascular Syphilis"; Barr on "The Heart and Diseases of Internal Secretion"; Roesler on "Cardiac Hypertrophy and Dilatation"; Levine on "The Cardiac Patient as a Surgical Risk"; and Wilson on "The Form of the Electrocardiogram."

The two volumes are actually a group of monographs which are excellently coördinated into a very complete text on diseases of the heart. The illustrations are numerous and carefully selected and the printing is excellent. These volumes are of decided value to anyone interested in diseases of the cardiovascular system.

DOCTORS IN SHIRTSLEEVES. Musings on Hobbies, Meals, Patients, Sport and Philosophy. By Sir Henry Bashford. 294 pages. Price $2.50, cloth binding. New York: Veritas Press, 1940.

This is a book outlining the interesting avocations and hobbies of doctors of medicine, mainly Englishmen. It indicates how a man may profitably (especially as far as maintaining health is concerned) spend his leisure hours. Some of the avocational activities are unique in character and worth emulating.

HEART FAILURE. By Arthur M. Fishberg, M.D., Associate in Medicine, Mount Sinai Hospital, New York City. Second Edition, thoroughly revised. Illustrated with 25 engravings. Philadelphia: Lea & Febiger, 1940. Price: $8.50.

Fishberg's well-received monograph is presented here in the second edition to include the notable advances which have resulted from clinical experimental investigations recently. These advances are translated into advice applicable to everyday practice. The signs of impending cardiac failure and a clear discussion of what should be done and how much to expect, makes this a valuable book to the general practitioner as well as to the specialist.

Have You Moved?

It is important that the mailing list of THE JOURNAL of the Michigan State Medical Society be kept up to date and accurate. Members are invited to help us in this work. When and if you change your mailing address, please drop a card to THE JOURNAL, giving your new address. If you would like to have your copy of THE JOURNAL sent to your home instead of your office (or vice versa), write the Executive Office, 2020 Olds Tower, Lansing. Please submit changes in address promptly to assist THE JOURNAL in avoiding delay in making mailing list revisions. We desire to have THE JOURNAL reach you each month without delay.

STUDIES IN THE AVITAMINOSES

This page is the final of a series on vitamin deficiencies presented by the research division of The Upjohn Company because of the profession's widespread interest in the subject. A full color, two-page insert on the same subject appears in the December 7 issue of The Journal of the American Medical Association.

The Exacerbation of LATENT PELLAGRA by Acute Infections

Vitamin requirements are increased by many factors, especially by acute infectious disease. Field, commenting on this phenomenon, states that the onset of pellagra may coincide with pregnancy, organic gastrointestinal disease, severe and prolonged illnesses, and dietary restriction for therapeutic purposes. The patient whose tongue is shown developed this manifestation of pellagra during the course of lobar pneumonia. After nicotinic acid therapy was started she coughed up a cast of the esophagus which consisted of a grey membrane similar to that covering the tongue. The pellagrous symptoms responded promptly to treatment.

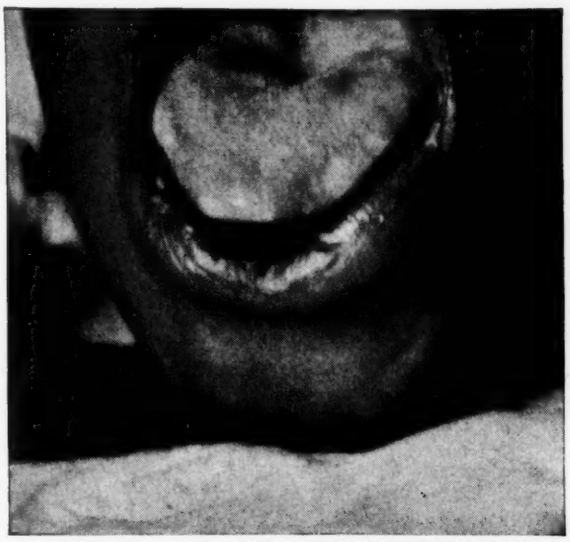

Illustration courtesy of Virgil P. W. Sydenstricker, M.D., University of Georgia Medical School, Augusta, Ga.

Illustration courtesy of Virgil P. W. Sydenstricker, M.D., University of Georgia Medical School, Augusta, Ga.

The Coexistence of Vitamin Deficiency States

Many authors have recently presented evidence that vitamin deficiency states often are multiple. Strauss has called attention to the fact that deficiency disease in man, unlike that experimentally produced in animals, is rarely limited to a single factor. The patient whose hands are shown had partaken of a markedly deficient diet for several months. As a result, scurvy and pellagra developed concurrently. The ecchymoses of the former and the dermatitis of the latter are clearly visible. Specific therapy together with dietary adjustment led to prompt remission of these signs.

UPJOHN

THE JOURNAL

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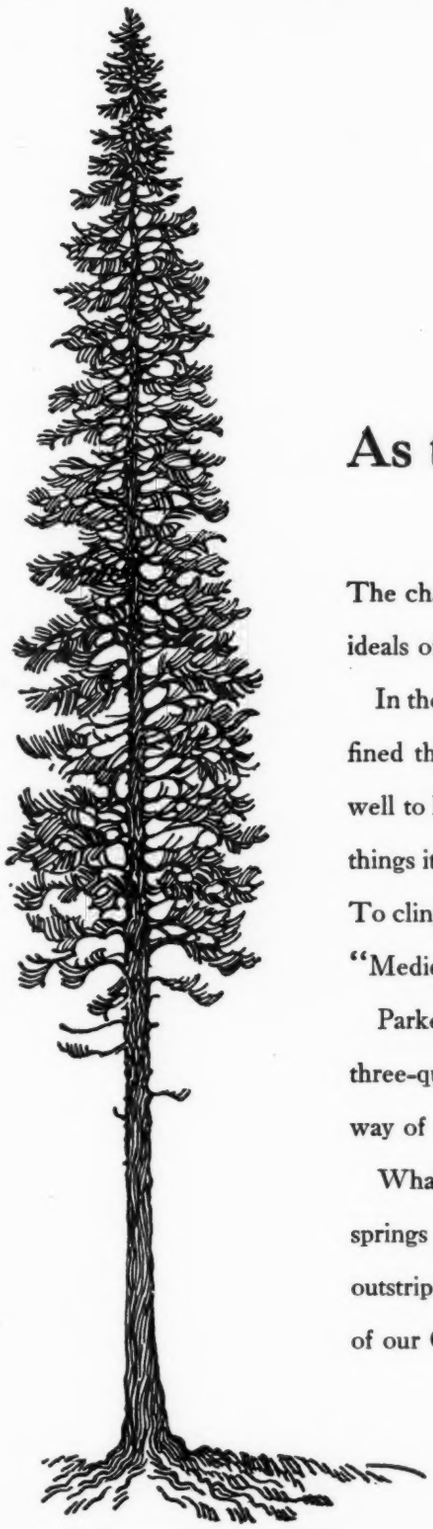

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CANNED FOODS IN THE MODERN PATTERN OF NUTRITION

● Generalities as to human nutritive requirements are of but limited use in the practical application of our modern knowledge of nutrition. This is particularly true where expert and experienced advice on diet formulation is not readily or conveniently available. For those concerned with actual diet planning or administration, more specific information on nutrition is desirable.

During recent years, several excellent texts have become available which present reliable guidance in diet planning (1, 2, 3). One important factor governing conformance with any diet pattern, of course, is the economic status of the individual, family, or group. A recent text presents a workable system in which rather full consideration has been given to this factor (1).

Under this pattern, the common foods have been classed according to their nutritive contributions into some 12 groups. These groups include milk; potatoes and sweet potatoes; mature dry legumes and nuts; tomatoes and citrus fruits; leafy green and yellow vegetables; other vegetables and fruits; eggs; lean meat, poultry, and fish; flour and cereals; butter; other fats; and sugar. There will, of course, be quantitative differences in the nutritive values of individual foods within a single group. However, there is sufficient similarity so that the foods within a group can be used interchangeably as conditioned by factors such as availability, relative costs, and personal, racial, or religious preferences. In order to minimize variation of nutritive values obtained from each food group, it has been suggested that as wide a variety of foods within a group, as practical, be consumed.

In connection with this diet plan, desirable yearly food allotments for persons of various sex, age, or conditions of life are also listed in terms of these twelve food groups. Thus, from information regarding the sex, age, and activities of the members of a family or group, one can compute the yearly amounts of the various foods which should be provided. From the sum of these yearly totals, the food allowances per week or month for the family or group can be estimated. The latitude in the choice of foods, within the twelve specified food groups, makes the diet pattern more adaptable to situations where the economic factor must be considered.

Estimation of food requirements in this manner provides a practical method of diet planning designed to supply the nutritive requirements of an individual, a family, a group, or even a nation. However, the ultimate achievement of an improved nutritional status is dependent upon a readily available supply (at all times) of the various common foods at reasonable cost. It is apparent from the listing of the twelve food groups that many materials of a perishable nature—which are not conducive to year-round production near the centers of large populations—are indispensable in supplying the dietary requirements of our people. Thus, the transportation and storage of foods, in such a manner as to retain nutritive values, are important problems to be considered.

Needless to state, commercially canned foods are well adapted for use in this diet plan. Commercial canneries are located near the sites of abundant supply of freshly harvested foods. The canning processes convert the perishable foods into nutritious canned foods which can be economically transported and marketed throughout the year. Hence, the canning industry plays an important role in the practical aspects of diet planning to improve the nutritional status of the American people.

AMERICAN CAN COMPANY
230 Park Avenue, New York, N. Y.

REFERENCES

1. 1939. Food and Life; Yearbook of Agriculture, U. S. Dept. of Agriculture, U. S. Govt. Printing Office, Washington, D. C.
2. 1939. Accepted Foods and Their Nutritional Significance, Council on Foods of the American Medical Association, Chicago.
3. 1940. J. A. M. A. 114, 548.

We want to make this series valuable to you, so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned-foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles. This is the sixty-sixth in a series which summarizes, for your convenience, the conclusions about canned foods reached by authorities in nutritional research.

The Seal of Acceptance denotes that the statements in this advertisement are acceptable to the Council on Foods of the American Medical Association.

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Variable Edema Duration

due to the varying methods of cigarette manufacture

(as shown by rabbit-eye test)*

Upon instillation of smoke solution from *Philip Morris* Cigarettes

Average duration
8 MINUTES

Upon instillation of smoke solution from cigarettes made by the *Ordinary Method*

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45 MINUTES

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When *smokers* changed to Philip Morris, every case of irritation of the nose and throat due to smoking cleared completely or definitely improved.

**Proc. Soc. Exp. Bio. and Med., 1934, 32, 241-245*
***Laryngoscope, 1935, XLV, No. 2, 149-154*

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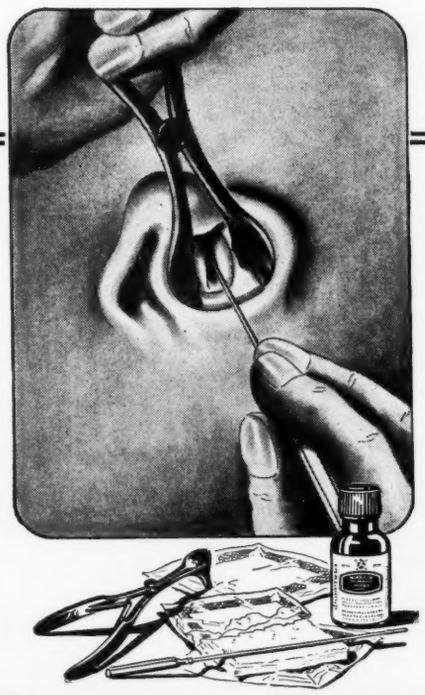

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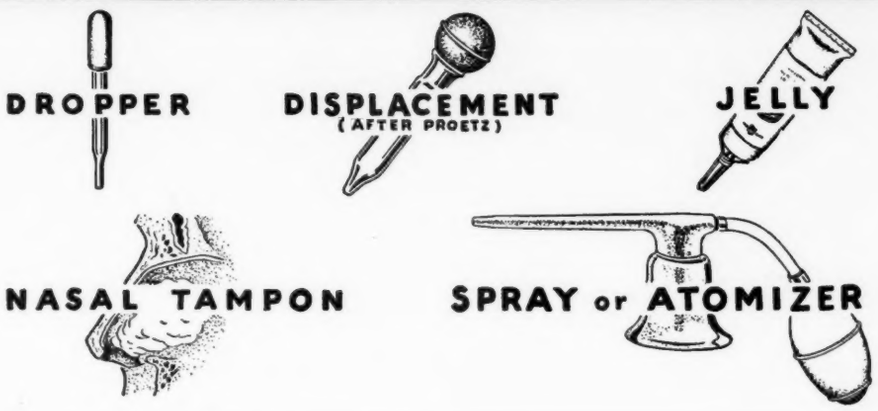

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